Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type										Leg	ible.		
		For		State	e of M	1arylan					and M	lental Hy	giene	21	0.1.0) 15	501
		State Registrar					Cer	tificate	of D	eath			Reg. No.		0/2		50
Physiciar	/	1. Decedent's Nam-										2. Date of Dea Month	Day		Year	3. Time of I	- 1
Medica	al .	Anni 4a. Facility Name <i>(if</i>						4b. City,	Tarrana da	Location	of Doath	May 1		012	of Death	9:3	UA'''
Examine	er	Manor C				1e		4b. City,	Town, or		or Death		1	- '	timo	re	
Funeral		5. Social Security N		6. Sex	_		ast birthday)	If Under	1 Year	If Under		8. Date of Birt	h		9. Birthp	lace (State or	Foreign
Director		214-24-	5369	1 □ M 2 □	XF	88	Yrs.	Months	Days	Hours	Min.	(Month, Day Aug. 1	7, 1	923	Coun: VA		
d ow		Usual Residence of 10a. State	of Decedent			10c Cit	y, Town or Lo	cation							1	0d. Inside Cit	v Limits
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or 288		10e, Street and Nur		timore			Towso	n 10f. Zip	Code	-			10g. Cit	izen of V	Vhat Cour		
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should and N is ma auma		19a. Informant's Na	ame/Relations	hip (Type, Print)			19b. Mailir	ng Address	(Street a	and Numb	er or Rura	al Route Numbe	r, City or	Town, S	itate, Zip (Code)	
nd 2 s ealth m 27 ner tr		Cynthia		in (daı	ught					Road		e. Fel	ton	, PA	173	22	
t of H If ite or oth		20a. Method of Disposition 1X Burial 2	,	3 Removal	from Stat		Place of Dispo cemetery, crer	natory or o	ther plac			Date			-	own, State	
t. Pag ntmen rtant:		4 Donation			_	Ва						y 18,2				more,	Md.
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Eu	neral	e								gs Fun					
	_	23a. Part 1. Enter	the disease, or	complications	that cause	d the deat			e of dying	Pres	ton cardiac	St. B or respiratory ar	alt∢ rest,	∋ , M∢	d. 2	1 2 1 2 Approximate	
HOME STORY		shock, or hea Immediate Cause	art failure.List	only one cause of	on each lir							Three		· · · · · · · · · · · · · · · · · · ·		Interval Bety Onset and D	
Pnynician/ Medical		disease or condition resulting in death)	òn	a. —	e to (or as	a consequ	uence of):	arci	roesc	ue	ar	/ crves	W. Francisco		-		
Examiner		De la companya de la	27 000 750		- 50	Trobe									51	Wee	125.
-	Examiner	if any, leading to in cause. Enter Under	mmediate	Du	e to (or as	s a consequ	uence of):										
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Physician: The law requires that the death certificate be ex- this certificate has been signed by the attending physician real director, page 2 should be detached for use as the buria	Physician/Medic	_		d													
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atter	iciai	in the past 12,	months?	4 🔲	Pregnant	at time of		Ectopic Other (sp		У				Mo	onth	Day Y	/ear
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Atten r dea: ctor; by the	Certificate:	3 Suicide 4 Homicide	6 🗌 Could	not be 28e.	Place of Ir	njury - At h	ome, farm, str	eet, factor	y, office			28f. Location (er or Rura	al Route Numb	per,
al or safte		4 LI HOITIICIDE	deteri	inied	ouilding, e	etc. (Specif	y)					City or To	wn, State	·)			
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral di	Medical	29a. Certifier	1 Certifyin	g Physician: To Examiner: On th	the best of	of my know	rledge, death	occurred a	t the time	e, date an	d place, a	and due to the o	ause(s) a	and man	ner as sta	ted. ause(s) and ma	nner stated.
the H nin 24 the Fi	Me	only one)	3 Certifyin	Nurse Practit	ioner: To	the best of	my knowledge	, death occ	urred at t	he time, d	ate and p	lace, and due to	the cause	e(s) and i	manner as	stated.	
5 vitt		29b. Signature and	title of certifie	7/	1			290	i. License	e number	49		29d. Da	ite signe	a (IVIONIN,	Day, Year)	
,		30. Name and add	1016	Mila	ain	7	- 00*\ 0"	Drint\		-0	((4)			73 .	
N		30, Name and add	ress of person	who completed	cause of	760	O O	SLE	K	B	- 5	Toevso	N	MI	0	1200	7
Stat	e	31. Date filed (Mon	th, Day, Year)	3 2012	32. legis	trar's Signa	atur	ز جد رو	•								
Registra	ır		NAY 1 (3 2012	Au	w,	B. 490	acres									_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Loretta Counts Gretzinger 2012 ear 13 11:20p May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Gilchrist Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 236-22-6679 Director 1 - M 2 X F May 18 1920 KY show 10c. City. Town or Location 10d. Inside City Limits 10a. State items 23a or 28a-f sho ner must be notified at Director Sykesville MD Carrol1 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 21784 6627 Marvin Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Was Decedent Armed Forces?
1 ☐ Yes 2 X No Examiner Black White etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Social Security Adm. the claims examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Joseph Allison Counts Irene Quillen Tedder 19a. Informant's Name/Relationship (Type, Print)

Dr. Brenda Gretzinger (daughter) 73 Sable Ct., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 X Removal from State 5-19-12 Knollkreg Cemetery Abingdon, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ≗h, sician/ WEEKS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** VULAR Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ATRIAL FIBRILLATION 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of PULMONARY HYPERTENSION 24a, Was an autopsy death? performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Y Other (Specify) Hospital 2 X No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 64395 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA, MD 21044 6336 CESAR LANE ERMANIMA DANIEULE 32. Regist State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-copier FH G928 6/01/2012 IIII and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 18. 31 P M 2. Date of Death GIVENS Month MAY Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR BALTIMORE HOSPITA N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) Apr 3, 1942 Country) Hours MD 1 🗆 M 2 ื F 70 Director 212-40-0731 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

7 item 27 is marked other than "natural", or items 23a or 28a-f sho if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State Director Yes 2 No **Baltimore** N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21225 824 Bridgeview Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give ģ Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 - Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Own Home** Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Sledge Albert Wilson permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic to 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21225 2458 Terra Firma Road, Anna Johnson Baltimore, 20c. Location - City or Town, State
Catonsville
Baltimere, Maryland 20a. Method of Disposition

+ ★ Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Metero creens you dece 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility
 Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CVA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Exami as the burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be ethin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregna 5 Other (specify) Ectopic pregnancy Por in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown detached 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 M No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA မ pletely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury_at Certificate: Matural Natural injury 5 Pending work? 1 \sum Yes 2 🗌 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year)
MAY 109g 2012 29c. License number RES001 29b. Signature and title of certifier dax 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S.HANOVER STREET, BALTIMORE, MD, 21225 NADEZDA TATARKINA 31. Date filed (Month, Day, 6 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 15504 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:40 VEL TREENL -YN 2012 MA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death OREST HAVEN BALTIMORE NURSING HOME ATONSVILL 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min Months 218-26-1665 1 M 2 XF 100 Director 1/13/1912 MD 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director notified 28a-f 1 Yes 2 No MD BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be Funeral 23a 701 EDMONDSON AVENUE 21228 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. þ ō 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the UNKNOWN UNKNOWN UNKNOWN UNKNOWN of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a TERRY SULLIVAN - GAURDIAN CALVERT ST. #200 BALTIMORE, MD. N 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or c Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 5/18/12 BALTIMORE, MD Signa 22. Name and Address of Facility SKARDA FUNERAL HOME M01120 2829 HUDSON ST BALTIMORE 232 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dement Physician. 95 CHIEF disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed the burial-trag Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Dav Year Pregnant at time of death signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed pinode peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗎 DOA ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be Accident filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, taymore Mille 147683 15 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ray mond Miller 1525 Owings MD Mills 21117 31. Date filed (Month, Day, Year) State 1 6 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 150 AM Physician/ ula Gross Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** ltimora Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth If Under 1 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) MD Director 10d. Inside City Limits show 10c. City, Town or Location 10a. State at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No ms 23a or 28a-f s must be notified MD BAUTIMORE 10g. Citizen of What Country? 10e. Street and Number GOUGH Funeral 21231 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Examiner Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: BLACK If Yes, Give 3 ☐ Widowed 4 X Divorced "natural", Completed Year or Dates Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) BATTIMORE CITY Elementary/Secondary (0-12) College (1-4 or 5+) WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) Eather's Name (First, Middle, Last) Mitchell မ Alberta GREEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) homas Gross SON 10ne 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 Removal from State BAUTIMORE, MD /18/12 MEMORIAC 4 ☐ Donation 5 ☐ Other (Specify) VAUGHN GREENE FUNGRANSONS Funeral S-Wice Licensee 22. Name and Address of Facility MO155 YORK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months?

1 Yes 2 No
9 Unknown Month certificate has been signed by the atterirector, page 2 should be detached for Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) director, 25. Was case referred to medical Certificate: To Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 27. Manner of Death 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours area co...

To the Funeral Director: After Accident Investigation Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

		Building, etc. (Specify)	Į.	Oity or 10	
(Charle of	Madical Evamina	ian: To the best of my knowledge, death occurr on the basis of examination and/or investigatio Practitioner: To the best of my knowledge, death	 in my opinion, death occurred at 	t the time, date	and place, and due to the cause(s) and marrier stated
b. Signature and	title of certifier	lash	29c. License number 7708		29d. Date signed (Month, Day, Year)

State Registrar

Medical

H31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 15506

			For State Registrar	State of M	-	cepartment of Certificate of		and Menta	Reg.	7.11	12	15506
	Physicia	n/	1. Decedent's Name (First, Middle, I William Z. Gold	,				2. Date Mon 5	of Death th	Day Y	ear l	Time of Death
··· ve	Medic Examin	al	4a. Facility Name (if not institution, g			4b. City, Town,	or Location			12 2 4c. County of		9:31 PM
ne.) Lxaiiii	CI	17510 Sirgalaha			Ashtor			Montgomery			
	Funeral		,		e (In yrs. last birth	day) If Under 1 Yea Months Days		Min. 8. Date	of Birth th, Day, Yea	ar) g	Birthplace Country)	(State or Foreign
	Director		579-64-0290 Usual Residence of Decedent	1 X □ M 2 □ F	62 Y	rs.			12-194		srael	
	and show	or	10a. State 10b. County		10c. City, Town	or Location					10d. lr	nside City Limits
	Maryli 28a-f otifiec	rect	MD Montg	omery	Ashton						1	X Yes 2 No
	with the s 23a or 3 nust be no	eral D	10e. Street and Number 17510 Sirgalaha	d Way		10f. Zip Code 20861			_	Citizen of Wha J nited		5
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		13. Was Decedent of If Yes, specify Cul 1 口 Yes 2 区内			or No- c.)		American Ind White, etc. White	
21215-0036	hin 72 hou ne. than "nat u e Medica	omplet	15. Decedent ¹ (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4 or 5	(+)	Decedent's Usual Occu Give kind of work done ife. DO NOT use retired	durina mo	st of working		. Kind of Busir		У
121	ed witl	Be C	17. Father's Name (First, Middle, Las	4	Pre	sident	10.14.1			Corpora	tion	
Maryland	uld be file Mental H narked o	ToE	Sigmund Goldste	in				her's Name (First, M nces Kap				
	nd 2 shou eaith and m 27 is n		19a. Informant's Name/Relationship Claire Simmons			Mailing Address (Stree Eton Over]			-			
Baltimore,	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemetery	Disposition (Name of crematory or other plants Garde		Date 5-15-12		Location - Ci	,	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lit	ensee Kurt Bla	ake	22. Name and Addi		ity Danza e Pike, R	-	Goldber 11e, Ma	_	d 20852
	Physician/		23s. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	y one cause on each line	i.	t enter the mode of dy		s cardiac or respirat	ory arrest,		Inter	roximate rval Between et and Death
P	Medical Examiner		disease or condition resulting in death)	_ a	a consequence of		case					
F	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	a consequence of):						
0	icate be executed 3 physician and as the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):					-	
3760	ficate g phy as the	/ledical		d						_		
Box 68	Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		of pregnancy 2 Fetal death t time of death	3 ☐ Ectopic pregnal 5 ☐ Other (specify)	псу			23d. Date of Month	,	Year
s, P.O.	es that th signed by		Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause of	jiven in Par	t I. 23e		co use contribu		use of death?
ord	require been si should	lete						242	Was an			ndings available
Reco	The law cate has	Completed by							autopsy performed Yes 2 X	? prio		ion of cause of
ital	ysician; The is certificate I	<u>m</u>	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒No	Hospital:		Ot	h a	ath (Check only one				
of V	Phys r this eral di	은 ::	27. Manner of Death	28a. Date of injur	y 28b. Tir	patient 3 LI DOA	4 LJ N	lursing Home 5 2		6 Other (S	Specify)	
ou c	ath. r: Afte	icat	1 XNatural 5 Pending 2 Accident Investigat	(Month, Day	, Year) inj	ury wo	rk? Yes 2 [,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,u.y 000000		
Division of Vital Records,	al or Atte s after des l Director d in by th	Certificate:	3 Suicide 6 Could no 4 Homicide determine	be 28e Place of Injur		n, street, factory, office			tion (Street or Town, St	and Number o	or Rural Route	e Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2 Medical Exa	nysician: To the best of miner: On the basis of exurse Practitioner: To the	camination and/or	investigation, in my opir	ion, death o	occurred at the time,	date and pla	ace, and due to	the cause(s)	and manner stated.
	To the within complete complet		29b. Signature and title of Orifier	Q		29c. Licen D589	se number		29d.	Date signed (N	fonth, Day, Y	
	101		30. Name and address of person wh				, #10:	3, Olney,	Mary	1and 20	0832	
	Stat Registra	٠.	31. Date filed (Month, Day, Year) NAY 1 6 2012		Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15507 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth 12847PM Physician/ ERNEST ALE HARRIS-GIVENS Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Director 263-54-6319 1 M 2 XF FL73 JUNE 29,1938 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗶 Yes 2 🗌 No PG MD FORESTVILLE 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a 2900 NORMAN DRIVE 20747 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0636 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the GOVERNMENT 6 NURSE of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLIAM HAGAN EASTER REED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health : TERRI BROWN/DAUGHTER 2900 NORMAN DRIVE, FORESTVILLE, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS CEMETERY 17,2012 cemetery, crematory or other place, CHELTENHAM ò Department of Important: If any injury or 4 Donation 5 Other (Specify) MARYLAND POPE FUNERAL HOMES, P.A. Signatu e of Funeral Service Licen 22. Name and Address of Facility 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease or complications that shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year signed by the at be detached f P.O. signed by ulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed^a this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 4 No 1 🗌 Yes ဂ္ 1 DInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 20706

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Department of Health and New State of Maryland / Department of Health and New State of Maryland / Department of Health and New State of Peath Registrar	
	Physicia		1. Decedent's Name (First, Middle, Last) Virginia Haulsee	2. Date of Death 3. Time of Death 3. 45 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number) North Arundel Health & Rehab. Center Glen Burnie	4c. County of Death Anne Arundel
1	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birth (Month, Day, Year) 10/01/1924 9. Birthplace (State or Foreign Country) Virginia
	yland f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 ☐ Yes 2 🏝 No
	or 28a- notifie	Director	Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code	10g. Citizen of What Country?
	with the s 23a of ust be	Funeral	7927 Oakwood Road 21061	U.S.A.
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	امَ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	iin 72 hours ie. han "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
	e filed with ntal Hygien ed other ti event, the	To Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	Electronics The (First, Middle, Maiden Surname) Exton
Maryland	nd Mer s mark umatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run.	ral Route Number, City or Town, State, Zip Code)
	nd 2 st lealth a m 27 is			en Burnie, Maryland 21061 Date 20c. Location - City or Town, State
Baltimore,	. Page 1 a tment of H tant: If ite jury or otl		1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) Holly Hill Mem. Gard. 05/0	5/2012 Baltimore, Maryland
Bal	permit Depar Impor any in once,		21. Signature of Funeral Service Densee 22. Name and Address of Facility Ski Bruzdainski 1407 old Fastern A	Funeral Home, P.A. venue, Essex, Maryland 21221
09	Physician and bulkarian street be executed bulkarian street burial-transit	edical Examiner	Approximate Interval Between Onset and Death Jew MEDICAL EXAMINER	
Box 687	ath certifi attending for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
s, P.O.	requires that the des been signed by the s should be detached	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Veew TWYOW & Sto, COPD	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown
Division of Vital Records,	The law requate has beer page 2 shou	Complete	Hypertension, Dementia, Left stip	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ Yoo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	hysician: nis certific il director,	Be		lome 5 ☐ Residence 6 ☐ Other (Specify)
on of	nding Plath. r. After the funera	icate:	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 4pril, 2012 Unknown M 28c. Injury at work? 1 \(\subseteq \) Yes 2 \(\subseteq \) No	28d. Describe how injury occurred Subject fall.
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has I completely filled in by the funeral director, page 2	Medical Certificate: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home	28f. Location (Street and Number or Rural Route Number, City or Town, State) 7927 Oakwood Road Glen Burnie, MD
	ne Hospi in 24 hou ne Funeri pletely fill	Medica	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and or investigation and occurred at the time, date and place, and the place and the p	at the time, date and place, and due to the cause(s) and maillier stated.
	To the comp	-	29b. Signature and title of certifier Changeling MD 29c. License number 29c. 29c. License number 29c. 29c. 29c. 29c. 29c. 29c. 29c. 29c.	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANDELWAL/MD 312 HOSPITA	L DR. GLED BURNIF, Md.
2	Sto Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 1 2012	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day 13 Year **Physician** 05 10:45 AM Phyllis Carol Hoffman 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 19310 Club House Road Montgomery Village Date of Birth (Month, Day, Year) 10/30/1918 Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months Days Hours y) Unkn 149-01-1229 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examination partition at 1 XYes 2 □ No Director Montgomery Village MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19310 Club House Road 20886 **USA** Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 X Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrator 12 Department of Health and Mental Hy, Important: If item 27 is marked - any Injury or - any Injury or - -18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Wright Philip Hoffman ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9702 Shadow Oak Drive, Montgomery Village, MD 20886 Nancy Chetry / Friend altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 5/16/2012 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Double Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Mashall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed physician and the burial-transi Pleural Effusion Due to (or as a consequence of): P.O. Box 68760, Physician/Medical The law requires that the death certificate as attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 5 Other (specify) ed by the a ☐Yes 2 No 9 Unknown 9 Unknown signed b Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sh autopsy perform 2 X No 2 No 1 □Yes 1 TYes or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 055 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification; To After this 28a. Date of Injury (Month, Day, Year) while 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

neral Director; A
filled in by the fu death. investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifies

State Registrar

DHMH 17 Rev 1/2001

655

Wetkins

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Medical 4a. Facility Name (if not institution , give street and number or Location of Death 4c. County of Death City, Town, **Examiner**)ONI If Under 1 Year If Under 24 Hrs. Number 7. Age (In s. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** onth, Day, Year) 03/29/1942 Virginia Months Hours Min 1 M 2 □ F Director 231**-**56-5663 70 ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 □ No Duval <u>Jacksonville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9116 Bay Cove Lane 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
'Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done (life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manger <u>Automotive</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Emerson Hardy Kathleen Slavton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 9116 Bay Cove Lane, Jacksonville, FL 32257 Anne E. Hardy / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State . Page 1 permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/12/2012 Beltsville, MD <u>Chesapeake Crematory</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 V Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy erformed? 1 ☐ Yes 2 ☑ No Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely file 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St. Bathmore

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mav Month 5:28 2012 Stauffer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country) 213-48-1198 Director 1 □ M 2 🔀 F 57 May 27 1954 Maryland 27 Is marked other than "naturel", or Items 23e or 28e-f show treumetic event, the Madical Exterings must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 🔀 No Maryland Gibson Island Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1623 St. Giles Road 21056 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black. White, etc. 2 1 Never Married 2 N Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) during most of working (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Consultant Federal Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mentel item 27 Is marked ဥ Borcher Donald Ross Stauffer Dorothy Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 St. Giles Rd., Gibson Island, Maryland 21056 John Hyde / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Department of Importent: If eny Injury or once. HilltopServiceCorp. 5/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 21. Signature of Funeral Service I 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sud Qt Priysiciani disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of nijury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifile 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Mar					Mental H	ygiene	201	2 15512
		Registrar 1. Decedent's Name (First, Middle, Las	at)	Ce.	rtificate	OTD	eatn 	2. Date of D	Reg. No	, L O 1	3. Time of Death
Physicia Medic		~ ·	efferson					Month	13 ^{Da}	ZON	
Examir		4a. Facility Name (if not institution, give	street and number)		4b. City, T	own, or	Location of Dea	th	4c	. County of Dea	
Jones .		Seasons Hospice			If I be done		dallstov				ltimore
Funeral Director		5. Social Security Number 212-36-9493 Usual Residence of Decedent	=x	In yrs. last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min		$\frac{1}{\sqrt{19}}$	38 9. Bii	thplace (State or Foreign ountry) MD
and show	ro.	10a. State 10b. County	1	Oc. City, Town or Lo	cation						10d. Inside City Limits
Maryl 28a-f otified	ireci	MD Carrol	.1		Sykesy	7i11e	2				1 ☐ Yes 2 🙀 No
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ath wi	Funeral Director	6514 Ridenour Way	12. Was Decedent Eve	erin U.S. 13	Was Decede		1784	necify Yes or No	<u>-</u>	14. Race - Ame	SA wicen Indian
Maryland 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.		If Yes, specif			Specify Yes or No to Rican, etc.)		Black, Whit	
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lan	오	Daniel Timo	thy Riorda	n		1		Leanor V		,	
		19a. Informant's Name/Relationship (T) Mrs. Laura J. Mun	upe, Print) Imert (Daugl	hter) 202	ng Address (8 Sher	Street ar	nd Number or Ri Avenue,	ural Route Numb Sykesv	oer, City or ille	Town, State, Zi	p Code) 784
Baltimore, M bernit. Page 1 and 2 s Department of Health is Important: If item 27 is any injury or other tra once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Domaval from State	20b. Place of Dispo	osition (Name	e of her place)	Date	20c. Lo	ocation - City or	Town, State
timo : Page tment c tant: If jury or		4 Donation 5 Other (Specif		Lorraine	Park	Ceme	etery 5/				
Baltimo permit. Page Department of Important: If any injury or once.	_,	21. Signature of Funeral Service Licens	rught m	00764				AIGHT FU sville,			& CHAPEL, PA
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an: Th tifficate tor, pe	O	25. Was case referred to medical				26. Pla	ce of Death (Che		2 1 N	o 1 ∐ Ye	s 2 No
VITA nysicia	To B	examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 🗆 DO	Other		Home 5 Res	sidence 6	Other Spec	ment Hospice
ing Ph		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of injury (Month, Day, Y	/ear) 28b. Time of injury	28	c. Injury work?	at	28d. Describe			
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al or A safter I Direct		4 L Homicide determined	building, etc. (At home, farm, str Specify) 	eet, factory,	onice			(Street and own, State)		ıral Route Number,
DIVISION Of VITAL RECONDS, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Exami	sician: To the best of my ner: On the basis of exar se Practitioner: To the b	mination and/or inves	tigation, in m	y opinion	n, death occurred	at the time, date	and place	, and due to the	cause(s) and manner stated.
To the To the Committee	-	29b. Signatule and title of certifier			29c.	License	number		29d. Da	te signed (Mont	h, Day, Year)
		of pettery			D	605	3337		Ma	4 13 2	012
5		20 Name and address of person who o	mo 693	4 Aviati	Print)	ouly	evard Si	tene (Gler	Barni	e, Mdziowi
Stat Registra		31. Date filed (Month, Day, Year) MAY 1 6 2012	32. Registrar's	Signature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, bast) 3. Time of Death Month Physician/ 3:35 PM Johnson 2012 Medical 4b. City, Town, or Location of Death
Baltomore 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** CLRC RAVEN LOCH If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Country) 1 M 2 F Director 68 06/011 28a-f show 10c. City, Town or Location ä 10a. State Director Baltimore Examiner must be notified 1 Yes 2 No 10a. Citizen of What Country? 9 21216 Funeral USA items 23a oplar Grove & 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 0 þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a, Decedent's Usual Occupation (Give kind of work done during life, DO NOT use etired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier Be permit. Page 1 and 2 should be file.
Department of Health and Mental H.
Important: If item 27 is marked any injury or other. Juhnson 20a. Method of Disposition Place of Disposition (Na 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending work'? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
3 \$0.0 LOCH RAVEN BLVO 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20c, perffl, G927, 5/22/2012, WS

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month S Physician/ 6:45 AM nason Medical Facility Name (if not institution, give street and number) 4a. 4b. City, Town, or Location of Death 4c. County of Deat Examiner ltimore Sex 1 X M 2 □ F Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Unde If Under 8. Date of Birth Months Hours (Month, Day, Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation rash Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Gity or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any injury or o 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 19/2012 4 ☐ Donation 5 ☐ Other (Specify) Alberta, VA March FH- East 1101 E. North Ave. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Bledde disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence or): cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ≥ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director After this certificate has autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 \square Pending work?
1 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death one the 3 29b. Sid ature and title f certifie 29d. Date signed (Month, Day, Year) $M \cdot D$ 78217004 5-11-12 of person who completed cause of death (Item 23a) (Type, Prin St. * 4105, Balthuere, MD 31. Date filed State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death JOHNSON Day 06 Month MAY 18.14 PM Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARBOR HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) Country) 1 □ M 2 🗶 F Director -20-1933 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Funeral USA items permit. Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wi Abacus sustodian Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ပ Nowlin Brown Horace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) aloria 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/11/2012 Halethorpe, Arbutus Memorial 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATORY FAILLY Immediate Cause (Final ⊲Pnysician/ disease or condition Medical resulting in death) heart Block. Cardiopenic shock **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a con equence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending p d be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown To Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 V No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Medical Certificate: injury 1 🗹 Natural 5 Pending Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

29a. Certifier

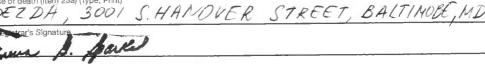
(Check

29b. Signature and title of certifier

State Registrar

NADEZDA 31. Date filed (Mon##, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



3001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

RES 001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Beatrice Jacobs 2012 12:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3210 Leisure World Blvd. #1001 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** 116-14-8251 Director 1 M 2 X F 86 1 - 23 - 1926New York Usual Residence of Decede or 28a-f show notified at 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 ms 23a or must be r Funeral 3210 Leisure World Blvd. #1001 20906 United States Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces Black, White, etc. þ 1 ☐ Yes 2 XNo 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White 3 Widowed 4 Divorced Completed Year or Dates er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Mode1 Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Abraham Gregerman Etta Mazer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Jacobs - Husband 3210 Leisure World Blvd., #1001, Silver Spring MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🌠 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns. 5-14-12 Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Danzansky-Goldberg Sage1 M00910 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Arteriosclerosis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 XNo detached for Month Dav Year Pregnant at time of death 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Dementia Completed page 2 should Beatrice peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe certificate 1 🗌 Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No Other: 4 Nursing Home 5 👿 Residence 6 Nother (Specify) Jacobs, မ 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical

301

Registrar

within 24 ho

To the Fune

completely f

29a. Certifier

(Check

only one)

29b. Signature and title of centrier

James Brodsky, MD - 4701 Willard Avenue, #224, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D20297

29d. Date signed (Month, Day, Year)

5-11-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5:44 PM 2012 **Physician** armond Jacquez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday 5. Social Security Number Days **Funeral** XXM 2□F 28, 1928 New Mexico Sept. 83 523-28-9767 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28a-f ehror any injury or other traumatic event, the Medical Event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Directo Prince George's Laurel 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 20707 U.S.A. 1113 11th Street Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

XX Yes 2 □ No 1948
If Yes, Give
Year or Dates: -1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2√XNo White Specify Specify: ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Parole & Probation vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Pilon Thomas Jacquez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20707 Maryland Shirley P. Jacquez / spouse 11th Street Laurel, 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ⅓ Burial 2 ☐ Cremation 3 ☐ Removal from State Ivy Hill Cemetery 5/16/2012 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4 / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. shock, or heart failure. Lis Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Oxic Epiderma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Reaction The law requires that the death certificate be executed that initiated events as the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Box 68760. Physician/Medical 23 Month IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 3 Ectopic pregnancy Day page 2 should be detached for in the past 12 months? 5 Other (specify) 2 □ No 9 Unknown P.O. the 9 Unknown signed by tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 V No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical director examiner? 1 ☑ Yes 2 ☐ No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 🗹 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? the funeral 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Fund 4 (18 12 After 5 Pending investigation 1 🗌 Natural 1 ☐ Yes 2 🗹 No Drug Reaction to Allopurnol MUNICIPANIA 2 Accident death. after death 28f. Location (Street and Number or Rural | oute Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be completely filled in by 4 Homicide determined 1113 Eleven St Laurel Home

or Attending Physician: To the Hospital within 24 hours a To the Funeral C hours a

X 15

11595

State Registrar

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (item 23a) (Type, Print) Reema 31. Date filed (Month 32. Registra 's Signature

and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

6

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

aula Sue Jala	ce	1- For State	aryland / Departmen <i>Certificate</i>	t of Health and Mental H		201	2 1551
Dhyeis	ion/	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate	OI DeallI	Reg. 2. Date of Death	. No	3. Time of Death
Physic Medical Exam			HACE			Day Year	0645 hrs
		4a. Facility Name (if not institution, give street	and number)	4b. City, Town, or Location of Death		4c. County of Death	
		3800 W. Belvedere Ave		Baltimore			
Funeral		Social Security Number	7. Age (In yrs. last birthda		8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Director		313-50-3853 1 M 2	VF 14	Yrs. Months Days Hours Min	17-14	-47 Foreig	NTADIANA Intry)
		Usual Residence of Decedent	01		1211	1/1	
any		10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
nd show	ے ا	MD	Ra	TIMORE			1 Yes 2 No
Aaryland 28a-f show i at once.	rector	10e. Street and Number	6374	10f. Zip Code	10g	. Citizen of What Coun	itry?
he M	Ö	3800W. BELVEDERE A	tem	21215		13.4.A.	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	쿋	11. Marital Status 12. W	as Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Americ	can Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ratel Hygiens red other than "natural", or items 23a or 28a-f shees, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married A	med Forces? Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
ffer d	•	3 Widowed 4 Divorced If Yes, 0		Yes 2 No specify:		Specify: Wh	NITE
ours a	d by	15. Decedent's Education (Specify only higher		edent's Usual Occupation (Give kind of		6b. Kind of Business/Ir	ndustry
72 h	Completed	Elementary/Secondary (0-12) Co	llege (1-4 or 5+)	ng most of working life. DO NOT use reti	rea)	D = 1	
5-0036 iled within 7. Hygiene. I other than	臣	12		WAITRESS		RESTAU	RANT
Hygive	ပြ			18.Mother's Name	(First, Middle, Ma	iden Surname)	
21215-C ould be filed v Mental Hygi marked oth	Be	I'AU V. JONES	34 (1975)	MAA	y Ehr	MRT	
MD 21215-00; 2 should be filed with h and Mental Hygiene 27 is marked other ti	유	19a. Informant's Name/Relationship (Type, Pri		ailing Address (Street and Number or I	- ,		
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati		MELISSA, JALKE-VASOLD, DAY 20a, Method of Disposition		SPRING AVE POSET	DAIE, MD	20c. Location - City or	Town State
altimore, MD 21215-0036 mit. Pages I and 2 should be filed within 72 hours parament of Health and Mental Hyggene. portant: Witem 27 is marked other than "natur inty or other traumstie event, the Medical Exam		1 Burial 2 Cremation 3 Rem		or other place)		- City of	TOWN, Otate
Pag ment tant:		4 Donation 5 Other Specify:	W. ARUND	E CREMATORY 5-1	2-12 (DOENTON, 1	YD.
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		21. Junature of Funeral Service Licensee		2. Name and Address of Facility DA	ughERTY	FUNERAL H	POME
	. (23a. Part I. Enter the disease or complications	00942	2601 MOUNTAIN RD. PA	SA DERA, A	10.Z1122	
Physician Medical		failure. List only one cause on each line.	that caused the death. Do not en	ter the mode of dying, such as cardiac o	r respiratory arrest	, snock, or neart	Approximate Interval Between Onset and
Examiner		and the second s	tensive Atherosclerotic Ca	ardiovascular Disease			Death
		Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	듵	cause. Enter Underlying Cause (Disease or injury that initiated c				/1	
si s 🛠	Examiner	events resulting in death) Last Due to (or as a consequence of):				
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50, tte be expression by sician expression burial	Medical						-
OX 6876 eath certificate attending phy for use as the 1	1	23b. Was decedent pregnant in the	If yes, outcome of pregnancy	Fetal death 3 Ectopic pregna	incv	23d. Date of delivery Month D	ay Year
Box 687 death certifice the attending place as the	cian/M	past 12 months?	Pregnant at time of death 5	Other (Specify)	incy	I World B	ay lea
BO) e deatl the att	Physic	1 Yes 2 No 9 Unknown 9	Unknown				
d by t		Part II. Other significant conditions contrib	uting to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the buri	d by				1 ✓ Yes	2 No 3 Prob	ably 4 Unknown
Records, The law requin ficate has been si	Completed				24a, Was an autopsy		opsy findings available impletion of cause of
DCO te law te has ge 2 s	ם				performe	ed? death?	
		25. Was case referred to medical		26.Place of Death (Check	1 Yes 2	No 1 Yes	s 2 No
Vital hysician this certi	Be	examiner? Hospital:	1 Inpatient 2 ER/Outpat			esidence 6 🗸 Other:	Scene
of V ing Phy After th	. To	1 ✓ Yes 2 No 27. Manner of Death 28a	Date of Injury (Month, Day,Year) 28b. Time		28d. Describe how		
DO On other Ather	[]	Natural 5 Pending	(Month, Day,Year)	1 Yes 2 No			
Division Lal or Attendi rs after death. al Director: /	ica	2 Accident Investigation 3 Suicide 6 Could not be	e. Place of Injury - At home, farm,	street, factory, office building, etc.	28f. Location (Stre	eet and Number or Rur	al Route Number, City
Division of Vital hin 4 Hospital or Attending Physician: hin 24 hours after death the Tuneral Director: After this certifin opletely filled in by the funeral director.	Certification:	odioide	pecify)		or Town, Stat		
Hosp 24 hor Fune		29a Certifier	he best of my knowledge, death o	ccurred at the time, date and place, and	due to the cause(s	s) and manner as state	d.
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 2 Medical Examiner: On the	basis of examination and/or inves	tigation, in my opinion, death occurred a			
To wit	Me	29b. Signature and title of certifier	nner stated.	29c. License number	2	9d. Date signed (Mon	th, Day, Year)
		//ill 1/ An O	1/2000	O.C.M.E.	1	May 11, 2012	
		30. Name and address of person who complete	ed cause of death (Item 23a)				
3		Victor Weedn MD JD _Assistar		W. Baltimore Street, Baltimo	re, MD 21223		
	tate	31. Date filed (Month Pay, 12a 6 2012		arke			
Regis		MAI 1 0 ZUIZ	Chieve p. of				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Mary M. Kukla 2. Date of Death 4/26/12 Physician/ 7:17pmMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 3/16/22 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** 138-12-5679 1 M 2 XX 90 Director New Jersey 10d. Inside City Limits show 10c. City, Town or Location 10a. State be notified at **Funeral Director** 28a-f 1 Yes 2 XNo Bel Air MD Harford 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number 23a 1312 Christopher Court 21014 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ◯ No 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married Completed by White Baltimore, Maryland 21215-0036 1 Yes 2 XXo Specify. If Yes, Give Year or Dates XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Banking Maintenance Worker 0 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ဂ Barney Burnes Margaret Donohue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 383 Flordia Grove Rd, Hopelawn, NJ Thomas Kukla / 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3XXRemoval from State 5/1/12 Holy Cross Cemetery North Arlington, NJ 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P. Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONGESTIVE HEART PAILURE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) ENDOCARDITIS, BACTERIAL **Examiner** Esqueritially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury STENOSIS, SEVERE MORTIC that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 1 Yes 240 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTAUOTNE LUNG DIFFAGE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Tyes 2 🗌 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🖬 No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours are death To the Funeral Director: A Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific w Novaleovely 008096 APRIL 26,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 35 FULFORD AVE BOLAIR MD 21014 ANDREW NOW AROWS MD State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sharon Month Physician/ 34 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner I Muyland Medical Cente Itimore Univesity 0 If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 213 66 9452 1 - M 2 XX **Director** 57 February 18 1955 Baltimore, Md. 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or ō Funeral 15 Leslie Avenue 21236 USA er than "natural", or items the Medical Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 XXMarried and 2 should be filed within 72 hours after theath and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Crossing Guard Baltimore County Police Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Clement Krueger Anna Achatz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian J. Kirsch Sr (Husband) 15 Leslie Avenue Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc May 14 2012 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore,Maryland 21236 ig atu e of Funeral Service Licenses se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the diseas Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day 4 Pregnant Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: ျှ 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 Louis MD

Registrar

State

MAY 1 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death 3altimore Baltimore enesis If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 🖳 M 2 🗆 F Months Hours 213-26-0146 4718/1929 Maryland Director 83 Iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2 XNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21236 4208 Darleigh Road 12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 TNo Specify "natural" 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Ith and Mental Hygiene.
27 is marked other than 'traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Engraver Silverware Manufacturing Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked only injury or other traumatic eventoe. ည Marie M. Tontrup Henry H. Klass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent F. Carlin III/brother-in-law 1104 Metfield Road Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/14/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature I Fam ral Service Licens 22. Name and Address of Facility 7401 Belair Road Baltimore, MD 21236 Lassahn Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** MID Saurentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit completed filled in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of) the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 100 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27 Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge at the time, date and place, and due to the cause(s) and mainer as stated 29b. Signature nd title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) ess of person who completed cause of death (Item 23a) (Type, Print) State 1 6 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month 9:45 May 9, Frances Marie Kepler 2012 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Wheaton Manor Care Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. If Under 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Days Hours Min (Month, Day, Year) 346-26-4979 1 🗌 M 2 🗓 F 83 July 31, 1928 Portsmouth, Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Wheaton Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20902 USA 11901 Georgia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes Give 3 X Widowed 4 ☐ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Clothing Store College (1-4 or 5+) Elementary/Secondary (0-12) Retail Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Johnston Audley Condon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Marie Kepler / Daughter 22 Ridge Road, #222, Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/10/2012 Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Corobral Vaccular Accident

Physician/ Medical Examiner

Department of H Important: If Ite any injury or ot

Physician/

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ral", or items 23a or 28a-f shov Examiner must be notified at

"natural"

other traumatic event, the Medical

Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. cant: If Item 27 is marked other than

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the burial-trar attending physician use a ed by signt 1 be c page 2 s after de. •al Director: A

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	disease or condition	OCICDIAI VADOLIAI MOCIATIO		
	resulting in death)	Due to (or as a consequence of):		
		Respiratory Failure		
D	Sequentially list conditions, b.	Due to or as a consequence of:		
	cause. Enter Underlying Cause (Disease or injury	Hypertension		
- 70	that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
ō	,			
2	d			
Ä	IF FEMALE:	3c. If yes, outcome of pregnancy		23d. Date of delivery
ō	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal death 3 Ectopic pregnancy		Month Day Year
2	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)		
Ē		tributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacco	use contribute to the cause of death?
Š	Dementia	induling to death but not resolving in the anderlying exact gives an asset		2 No 3 □ Probably 4 □ Unknown
ב	Demencia		I L Yes	Z M NO 3 - PIODADIY 4 - CINNOWII
			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
2			performed?	death?
5	25. Was case referred to medical	26, Place of Death (Chec.		12 160 22 110
	-uaminar?	ospital: Othor:	me 5 Residence	C Other (Presite)
2	27. Manner of Death		28d. Describe how init	
ale	1 X Natural 5 ☐ Pending	(Month, Day, Year) injury work? M 1 \[Yes 2 \] No	200. 2000/120 /1011 1119	
<u></u>	2 Accident Investigation 3 Suicide 6 Could not be		005 1ti (Ctt-	and Number or Rural Route Number,
en	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	te)
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redical	(Chook 2 Medical Evamine	cian: To the best of my knowledge, death occurred at the time, date and place, a er: On the basis of examination and/or investigation, in my opinion, death occurred a	t the time, date and pla	ce, and due to the cause(s) and mainler stated.
ē	only one) 3 Certifying Nurse	Practitioner: To the best of my knowledge, death occurred at the time, date and pl	ace, and due to the cau	se(s) and manner as stated.

29c. License number

D35791

29d. Date signed (Month, Day, Year)

5/10/2012

State

Registrar

within 24 hor To the Fune completely f

ž

29b. Signature and title of certifier

31. Date filed (Month, Day, Year

b

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

Marlyn Vemury, M.D., 9801 Georgia Avenue, Suite 227, Silver Spring, MD 20902

and and a Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 1047A M erry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, Months 284-48-6767 1 □ M 2 🛛 F Director 63 Yrs. October 13, 1948 Dayton, Ohio Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Upper Marlboro Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20774 USA within 72 hours after death with 13208 Vandine Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 Divorced 4 Divorced Completed Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Howard Bailey Fannie Elizabeth Talley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Charles B. Kirkland / Husband 13208 Vandine Street, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/18/2012 Suitland, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ netostic disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical P.O. Box 68760 as IF FEMALE: s, outcome of pregnancy Live Birth 2 Petal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months for Pregnant at time of death 5 Other (specify) 9 Unknowr ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Aortic murel No 3 Probably 4 Unknown Division of Vital Records, tension, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 4 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours after oeau..

To the Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05-15-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PArh 2001 Medical

State

Registrar

31. Date filed (Month, Day, Year)

6

2. Registrar's Sign

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIEM#5perFH, G928, 6/5/2012, WS State of Maryland / Department of Health and Mental Hygiene 2012 1552											
		•	For State Registrar	State of Marylan	Certificate of			Reg. No.	2 15524			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Jac 9 4 6 1 4 7		Kerpeten	091u	2. Date of Dea Month MGY	Day Year	3. Time of Death 2 0055 M			
	Examine Director Funeral Director Funeral Director	Director	4a. Facility Name (if not institution, give s The Johns Hoff 5. Sorial Saguity 6 228 Usual Residence of Decedent 10a. State 10b. County ANNE IF 10e. Street and Number	KINS HOSPITA 7. Age (In yrs. Ia 10c. City	al Battir		8. Date of Birth (Month, Da)		rthplace (State or Foreign ountry) 10d. Inside City Limits 1 Yes 2 No			
920	e filed within 72 hours efter death with the Maryland tal Hygiene. ad other than "naturel", or items 23e or 28e-f show event, the Medical Evariner must be norfiled at	ed by Funeral	29/9 DAVIDS 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates.	2/03	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	erican Indian,			
121215-0036		Be Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retired Adm/N/S	during most of world	,	16b. Kind of Business	eshone Co.			
Maryland	should and Mer is mark	To B	17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Typ	Yealdhal Daughter	19b. Mailing Address (Street	18. Mother's Nan	NSC A	E. Yea	Idhall ip Code)			
Baltimore, N	t. Page tment o rtent: If njury or		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State / 100	lace of Disposition (Name of emetery, crematory or other plane)	Ry 5/1	Date 4/20/2	20c. Location - City of Balhmon	MD 21035 r Town, State			
Bal	Depar Depar Impo any ir	,	21. Signature of Funeral Service License)	Home, P	ess of Facility <i>B</i>	Willow	-ASKLON A SOCINCR	-uneral			
	Physician/ Medical Examiner	J.	23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a conseque)	PSIS ence of):	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death			
09	ite be executed hysician end he burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last	Due to (or as a consequ Due to (or as a consequ			_					
). Box 68760	The law requires that the death certificate be are has been signed by the attending physici page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 🗌 Ectopic pregnan	юсу		23d. Date of do Month	elivery Day Year			
rds, P.C	requires that been signed t should be det	þ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the underlying cause g	iven in Part I.			Probably 4 Nnknown			
al Reco	an: The law r tificate has b tor, page 2 s	Be Completed	25. Was case referred to medical		26. F	Place of Death (Chec		sy prior to med2 death?	utopsy findings available completion of cause of			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 DOA Ott 28b. Time of injury 28c. Inju	ner: 4 Nursing H	ome 5 🗆 Resid	ence 6 Other (Spe	cify)			
Divisi	itai or Atturs after de rai Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, street, factory, office		28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,			
	the Hosp hin 24 hou the Funei npletely fi	Medical	(Check 2 Medical Examine only one 3 Certifying Nurse	er: On the basis of examination	edge, death occurred at the tirr and/or investigation, in my opin ny knowledge, death occurred at	ion, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.			
	S o with		29b. Signature and title of certific	lie	29c. Licens		I	May 15)				
	2 √		30. Name and address of person who co	lison		1800 N.	Orleans	St. Baltin	2012 Nove MD 21487			
	Stat Registra		MAY 1 6 2012 A	32. Registrar's Signati	arker							

amend 30, per DVR, g927 5-16-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 05 **Physician** DYLVLA LAFFERTY /Medical 4c. County of Death 4b. City, Town or Location of Death

BALTIMOKE 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GON SECOURS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** Hours Months 1 ☐ M 2 🗙 F 217-76-8823 10/18/64 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f ehow 17 is marked other than "natural", or itams 23a or 28a-1 enov traumatic event, the Medical Examiner rount by notified at MD N/A Baltimore MXYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 USA 206 S. Payson Street 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 □ Yes 2 XXIII o If Yes, Give Year or Dates: 1 Never Married 2 Married White ŏ 1 ☐ Yes 2XXXVo Specify Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nat College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Molly Lafferty Harry Knight ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 432 E. Lorraine Ave, Baltimore MD 21218 Tabatha M. Geisler /DAughter Health i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or ot once. PBurial 2 ☐ Cremation 3 ☐ Removal from State 5/8/12 Holy Cross Cemetery Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Sixal ve of Lineral Service Licensee Victor Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** REMAL FALLURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Glor Attending Physicien: The law requires that the death certificate be executed BLEEP Due to (or as a consequence of) physician a s the burial-Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy I Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an A No certificate WORUSIS 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 3 Z No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cen 170720 use of death (Item 23a) (Type, Print) 30. Name and address of person IDDIAN Bon Secours Hospital 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5:26 PM Physician/ 2012 MADE MAY LUDWI 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARBOR HOSPITAL BALTIMORE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. If Under 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 212-30-0296 1 🗆 M 2 🗶 F 80 **Director** Maryland 9/27/1931 10d. Inside City Limits 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 X No Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 23a USA 21227 200 !st Avenue, Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) Paint Brush Machine Operator should be filed with and Mental Hygien. 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Hilda D. Letchen George A. Norris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is n any injury or other traumone. 1651 Foolish Pleasure Ct., Annapolis, MD 21409 Catherine E. Cerniglia / Daug. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State MD. Veterans Cemetery 5/21/2012 Crownsville, MD. Nonation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. e of Funeral Service Licensee 4107 WIlkens Avenue, Baltimore, Maryland 21229 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final RESPIRATORY FAILURE - Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner PLEURAL EFFUSION/COPD ATELECTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last burial-transi HYPOTENSION and Due to (or as a consequence of) physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy Dav in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unknown ATRIAL FIBRILLATION, CHRONIC KIDNEY 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an DISEASE, DIABETES MELLITUS page 2 s performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 M Inpatient 2 ER/Outpatient 3 DOA 2 X No 1 Yes funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 \square Pending 1 X Natural 1 Yes 2 No after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

Registrar

GEORGE SUSAN 31. Date filed (Month, Day, Year)

Swan George

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) MAY 12 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 5. HANOVER ST. BALTIMORE

29c. License number

RES OOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 65 bebman 2012 Medical 4a. Facility Name (if not institution, give street and number) County of Death Town, or Location of Death **Examiner** DITA avdalls Lowner LUN HUMOVE If Under 1 Year If Under 24 Hrs. Social Security Numbe Sex 1X M 2 □ F Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 0870271928 060-20-4469 83 **Director** Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If teem 27 is anawked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE OWINGS MILLS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral APT.222, BLDG 3430 ASSOCIATED WAY, 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify Completed WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ CHIROPRACTOR MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LOEBMAN RUTH STRULL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 SIMA LOEBMAN/WIFE 3430 ASSOCIATED WAY, APT. 222, BLDG. 5, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PARK 05/15/2012 RANDALLSTOWN, MD 21. Signatur 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and dedecached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown s been si should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ျ 1 Inpatient 2 ER/Outpatient ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Mann Certificate: eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year) State

30. Name and address of person

OUV+ 32. Registrar's

2012

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	1	State of Maryla State Registrar		artment of F tificate of L			iene _{eg. No.} 20	12 1552		
Physician/ Medical	1	Decedent's Name (First, Middle, Last) ELSIE		LONDON		2. Date of Death Month	Day 15 2	3. Time of Death		
Examiner	•	4a. Facility Name (if not institution, give street and number) Sinai Hospital of Baltimore 5. Social Security Number 6. Sex 7. Age (In yr.	rs. last birthday)	4b. City, Town, or Balt	r Location of Death More If Under 24 Hrs.	8. Date of Birth	N/A	c. County of Death N/A 9. Birthplace (State or Foreign		
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e, Marylanc and 2 should be file Health and Mental I em 27 is marked o ther traumatic eve		19a. Informant's Name/Relationship (Type, Print) LAWRENCE LONDON/SON	240	4 DIANA	and Number or Run	TIMORE,	MD 21209)		
Baltimore, bermit. Page 1 and Department of Hea Important, If item any injury or other		1 Burial 2 □ Cremation 3 □ Removal from State □ Donation 5 □ Other (Specify)	CHESED	AHAVAS CEMETERY	05/1	5/2012		LSTOWN, MD		
Balt permit. Depart Import any inji	-	21. Signature of Funeral Selvice L.S. nsee 23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.		8900 REI		ROAD, P	IKESVILI	E, MD 21208 Approximate		
Physician Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a cons	ated lef		al hernic			Interval Between Onset and Death 5 days 5 days		
be executed sician and surial-transit cal Examiner			ona monanti:					14 yea		
Hospital or Attending Physician: The law requires that the death certificate by A hours after death. 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the tending and Completed by Physician/Medical	nysician/ Med	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date Montl	*		
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DIVISII all or Atte s after de all Directo ad in by th	sal Certii	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Spe	ecify)			City or Town	, State)	or Rural Route Number,		
_ ## # # # # # # # # # # # # # # # # #	<u>∪</u>	29a. Certifier 1 W Certifying Physician: To the best of my kn (Check 2 Medical Examiner: On the basis of examinar)	ation and/or invest	tigation, in my opini	on, death occurred a	t the time, date an	d place, and due to	the cause(s) and manner st		
DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral Medical Certificate:	Med	only one) 3 Certifying Nurse Practitioner: To the best 29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ormand Isaac Logan 4a. Facility Name (if not institution, give sized and number) 4b. City, Town, or Location of Death Baltimore 4c. Country of Death Baltimore 1c. City, Town or Location 1c.	E Island Inside City Limits X Yes 2 No
## Colly, Town or Location of Death Good Samaritan Hospital ## Colly, Town or Location of Death Baltimore ## Linder's Year # Linder's Year Year	E Island Inside City Limits X Yes 2 No
O38-60-9465 1	E Island Inside City Limits X Yes 2 No
Usual Residence of Decedent 10c. City, Town or Location 10d. 10d. State I and Number 10d. State I and Number I and Number I and Number Rican, etc.) 11	. Inside City Limits Yes 2 No No ndian, Black,
100 Street and Number 101 Zp Code 102 Cilizen of What Country 103 Specify Search of Highest Chapter of Highest of	ndian, Black, try
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Rado - American Irray 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mailing Address (Street ano Number or Rural Route Number, City or Town, State, 2 pc. 19. Informant's Name/Relationship (Type, Print) 19.	try
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Carpet Cleaner Facility Management Fac	
Nkosaithi Jesse Logan Dietra Elizabeth McCain	
20a. Method of Disposition Company of the place of Disposition (Name of cemetery, crematory or other place)	
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Physician	D
failure. Lest only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as	A. 215 proximate Interval
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a cons	etween Onset and Death
AMENDED 5 per fh g927 5-16-12 vt 23a.pt.II.27.28a-f.per me.g928 6-12-12 sm 23d. Date of delivery	
AMENDED 5 per fh g927 5-16-12 vt 23a.pt.II.27.28a-f.per me.g928 6-12-12 sm FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
So the second the pregnant at time of death so the past 12 months? Cocaine Use Co	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the call the contribution of the contribution of the call the ca	Year
State of the control	findings available etion of cause of
THE SET OF SET O	
27. Manner of Death Yes 2 x No Subject ingested meth 1 Natural 2 x Accident 2 x Acc	hadone
The state of the s	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Date signed (Month, Date of the cause (Month), Date of the cause (M	
O.C.M.E. May 12, 2012	
30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Polister's Signature	
State 31. Date filed (Month, Day, Year) 32. Rightner's Signature Registrar DHMH 17 Rev 1/2001 ORIGINAL OCME	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ therine izabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Center e oncurd town, MD ST MANS Nursing mar Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1/30/21 Country) Wash. DC 579-14-0375 1 🗆 M 2 🔀 F Months Days Hours Min. 91 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director N/A Leonard Town 1 Yes 2XXNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21585 Peabody Street Funeral 20650 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Macyland 21215-0036 1 Yes 2 No Specify: White Yes. Give 3 Widowed 4XXDivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unk. Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hit: If item 27 is marked of y or other traumatic even ၉ Charles White Evelyn Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 475, Valey Lee MD 20692 19a. Informant's Name/Relationship (Type, Print) Diane Hurley /Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Ardent Crematory 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 5/9/2012 Hanover MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, uneral Home, Inc. Baltimore MD 21230 1501 E. Fort Avenue. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause weach line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence off: cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🏔 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗀 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nu 29b. Signatur and title of certific 29d. Date signed (Month, Day, Year) 14285 30. Name and address of per leted cause of death (Item 23a) (Type, Print)

State Registrar MAY 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Everett Lee McCormick 5:40 PM2012 May 11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing Home Montgomery Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 367-22-1201 Director 1 🏻 M 2 🗆 F 88 Yrs Herrin, Illinois August 19, 1923 Usual Residence of Decedent f show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Mount Rainier 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 3117 Queens Chapel Road, #102 20712 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 🖾 Yes 2 🗌 No ARMY
If Yes, Give 1943 –194 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Year or Dates. 1943-1949 1 Yes 2 No Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Vehicular Mechanic I Hygie Be 17. Father's Name (First, Middle, Last) should be filk h and Mental I is marked of 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Ephraim McCormick Lizzie Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trees. Mary Ann McCormick / Wife 3117 Queens Chapel Road, #102, Mt. Rainier, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematory 5/15/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition Heresclerote Cardiovascular Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Other (specify) Month Pregnant at time of death Day Year Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: ပ 1 Yes hours after death.

neral Director: After this
y filled in by the funeral di After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 05-19-12

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

6 201

ORIGINAL

, Situr Shor Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Gmins BLrs San

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#5perFH, G928,6/5/2012, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ May 14, 11:53 AM Daisy Messenger Medical Louise 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 720 Earls Beach Road Middle River Social Security Number 3364 212-22-3362 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Months Days Hours Min (Month, Day, Year) Director 1 M 2 X F 6/5/1927 Maryland 84 Usual Residence of Decedent show 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland Funeral Director r 28a-f sl notified 1 ☐ Yes 2X No Baltimore Middle River Maryland ms 23a or 2 must be no 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 U. S. A. 720 Earls Beach Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Xho
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced I Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Inspector Electronics permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Milton Mildred Louise Reid Bryan Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 720 Earls Beach Road Middle River, Maryland 21220 Robert Wayne Messenger, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5/17 2012 Department o Important: If any injury or Overlea, Maryland Gardens of Faith Mem. Gard. 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final REBROVASCULAR ACCIDENT Physician/ -MUN17+ disease or condition Medical resulting in death) e to (or as a consequence of) Examiner CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi The law requires that the death certificate be executed physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? SEVERE DEGENERATIVE USTECARTHRITIS 24a. Was an ate has l autopsy performed? Yes 2 XNo within 24 hours after death.

To the Funeral Director; After this certificate completely filled in by the funeral director, pag 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{XResidence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 L only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P016728 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Bo ZAW-WIN, ND 6830 (+05P, ML DR #104 BALTS MD 21237

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

			ForState	State of Marylar				Mental Hy	giene	010) (
			Registrar 1. Decedent's Name (First, Middle, Lasi		Cer	tificate of L	Jeatn	2. Date of De	Reg. No	U14	155	٢.
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أمسد	-		Laurel Regiona	ul Hospital		La	urel		Pri	nce (George's	
	Funeral		5. Social Security Number 6. Se	9 , 7	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th		place (State or Foreig	n
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	the n		10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?	
	ath wi	Funeral	1002 Turney Avenu	12. Was Decedent Ever in U.	S 13 V	20707 Vas Decedent of H	lispanic Origin? (S	Specify Yes or No-	U.S.A	ace - Americ	can Indian	
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bl	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,				
ylar	ld be fill Mental arked o	오	Ellsworth Marlow				Elizab	eth A. W	heeler			
Maryland 21215-0036	shou and is m		19a. Informant's Name/Relationship (Ty			g Address (Street					Code)	
	and 2 s Health lem 27		Betty L. Turney M 20a. Method of Disposition			Box 12.	l Laurel	, Maryla	nd 2072 20c. Location		nun Stato	
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, cren	cemeter		15, 12	Laurel			
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00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	_	d. Congestive	Heari	Failur	e					
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Division of Vital Records, P.O. Box 68	s that gned be de		Part II. Other significant conditions of Hypovolemia	entributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.				he cause of death?	
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DHMH 17 Rev 06-2011

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21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Marrled 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	Vas Decedent of H Yes, specify Cuba	Specify:	o Rican, etc.)	Specify	e - American Inck, White, etc.	dian,
215-	in 72 ho e. nan "na Medic	mple	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)		(Give k	ent's Usual Occup aind of work done of NOT use retired)	during most of wor	king	1	usiness Industry	
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	and 2 should I Health and Me tem 27 is marl other traumati		19a. Informant's Name/Relationship (T)	DEDANIEL-SIS		g Address (Street a		ral Route Numb		State, Zip Code) 21223	
Baltimore,	0 = =		20a. Method of Disposition 1 M Burial 2 Cremation 3	Removal from State	Place of Dispos cemetery, crem	sition (Name of natory or other plac	5-18	1 10	20c. Location	- City or Town, S	
altin	permit. Page Department Important: I any injury o		4 ☐ Donation 5 ☐ Other (Specifical Service License)			Name and Address	-	SVE PA		o, MD	
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	Cto		Reginald Mc Ke	ensie Brown		Paca ST.	Baltimo	re,MD 21	1201		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1350 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** Baltimor umma If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 213-36-7622 **Director** 1 M 2 X F 72 5/30/1939 MD or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes XX No Westminster MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or edical Examiner must be n Funeral with 1 88 W. Main St., 21157 USA Apt. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 X Never Married 2 Married þ 2 X No Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Self-Employed Caregiver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic William P. Miller, Sr. Miriam Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Littlestown Pike, Westminster, MD 21158 Pamela Seymour/Daughter Baltimore, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 5/18/2012 Winfield, MD Pleasant Ridge Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Seg 22. Burrier Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 20 disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events PROVED BY MEDICA Due to (or as a consequence of) resulting in death) Last Physician/Medical CERTIFICATION Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗌 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Year) 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending tall 0700M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Royte Number, City or Town, State) 4 Homicide determined 88 W main MD 21157 Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore 21201 22 vecke Greene 31. Date filed (Month, Day, Year, 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15536 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 05 Physician/ 2012 PM 2:00 Eugene Allen Nauman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil Earleville 9 Cecil Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. (Month, Pay, Year) 1X□ M 2 □ F Pennsylvania 67 Director 192-34-0910 Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Funeral Director Yes 2 No Cecil Earleville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21919 9 Cecil Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates. the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Electrician 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mae M. Wideman George H. Nauman III traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1783 Perryville Road, Perryville, MD 21903 Nicole Lee Miotla / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5/13/2012 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Maryland Cremation Services, PO box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ 40515 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that the death certificate be executed bunial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical P.O. Box 68760 attending phys for use as the I IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably Records, law requires Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy the Hospital or Attending Physician; The 2 🗌 No 1 Tyes 26. Place of Death (Check only one) director, 25. Was case referred to medica Division of Vital Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 Pending injury 1 Yes 2 No М Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and tipp of certifier

31. Date filed (Month, Day, Year)

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who completed cause of death (Item 23a) (Type, Print)

amend 7.per fh.g927 5-16-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 8.per fh.g927 5-16-12 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 02 6:15p 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** 1500 May Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 ▼ F - 67 - 68 Yrs. MD Director 216-42-9733 Aug 22, 1944-1943 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits 28a-f show Examiner must be notified at 1XIYes 2□No **Baltimore** Directo MD **Baltimore City** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ö 21231 II.S.A 1500 May Court "natural", or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2√ No Saltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify. Specify: Black þ 3 Widowed 4 □ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Abacus Cleaners Janitor 12 Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, th once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Jordan Raymond Jordan မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3925 Tiverton Road Randallstown, MD 21133 Robin Newman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State May 08, 2012 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician ar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as attending p IF FEMALE yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mm Month Day 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐Unknown 210 No 1 ☐ Yes been si 24a. Was an Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has certificate has rector, page 2 autopsy performe 1∐ Yes 212 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only oge) 20 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation Injury (Month, Day Year) 1 Unatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital to ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 15 2012 Margaret Mary Parker 8:40A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Stella Maris Baltimore County Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 212 26 6902 **Director** 1 M 2 XF 83 January 24 1929 Baltimore, Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hyglene. Importent: If Item 27 is marked other than "naturel", or items 23a or 28a-f show with Inury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐xNo Maryland Baltimore Baltimore County 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7434 Brookwood Avenue 21236 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Homemaker Housekeeping-Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Charles Braun Sr Marie Agnes O'Connell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R Braun Baltimore, Maryland 21236 6 Juxon Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State May 19 2012 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith Cem. Baltimore, Maryland 22. Name and Address of Facility
Lassahn Funeral Home Inc 21. Signature of Funeral Service License 7401 Relair Road Baltimore Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 Hlnknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The I 24 hours efter death. Funeral Director: After this certificate hetely filled in by the funeral director, page performed 2 🗌 No 1 Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) 2 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 3 ☐ Suicide 5 Pending work? 2 🗌 No Investigation 6 Could not be thin 24 hours efter de the Funeral Director impletely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ May 3, 2012 Lloyd E. Purnell 12:55a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death N/A **Baltimore** Joseph Richey Hospice, Inc. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min (Month Day Year 1 🕇 M 2 🗆 F Director MD 220-12-0189 90 May 22, 1921 Yrs Usual Residence of Deced 28a-f show 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No **Baltimore** MD **Baltimore City** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 U.S.A. 1700 Edmondson Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: If Yes, Give Year or Dates Specify Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **BGE Back Hoe Digger** should be filed with and Mental Hygien 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fletcher Purnell Frances Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health a Important: If item 27 is any injury or and and 2 s Health Baltimore, MD 21215 **Odessa Whittington** 3409 Wabash Avenue. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Elkridge, Md. 4 Donation 5 Other (Specify) Meadowridge Memorial Park May 11, 2012 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ChroNIC RENAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin y physician and as the burial-trans Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 use as attending Purnelle IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No ō Pregnant at time of death Month Dav Year signed by the ail 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ρ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown should been Joyd 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has l autopsy performe 2 🔀 No 1 Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Yes 2 X/No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Jopital o.
A hours after de.
Aral Director: Afte. 1 🗷 Natural 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Direct

completely filled in b Hospital Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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(Month, Day, Year)
MAY 1 6 2012

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Anthony Pindell	State of Maryland / Department of Health and Mental F 1- For State Certificate of Death	lygiene	201	2 1554
	Registrar	Reg. N 2. Date of Death	No.	3. Time of Death
Physician/ Medical Examine		Month Da May 10, 2012	y Year	1840 hrs
	Anthony Pindell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Death	
	St. Agnes Hospital Baltimore		Baltimo	re
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	· '	M/DD/YYYY) 9. Birt Foreig	
Director	212-86-5422 1XM 2 F 41 Yrs. Months Days Hours Min	01/08/1		untry) MD
	Usual Residence of Decedent			10d. Inside City Limits
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ith th	102 Cherry Lane 21060 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (\$		SA 14. Race - Ameri	can Indian, Black,
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ours a sami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		b. Kind of Business/li	ndustry
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5-0036 ed within 72 hour lygene. other than "natu the Medical Exan Completed	12 Warehouse 17. Father's Name (First, Middle, Last) Warehouse 18. Mother's Name	e (First, Middle, Maid	UPS Ship	ping Co.
215- be filed ntal Hy rked of ent, the				
212 Ment Ment in article even				, Zip Code)
nore, MD 21215-0036 spes 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygene. It: If item 27 is marked other than "natural", or items 23a or 28s-f sho other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Renee Spencer 102 Cherry Lane,			
Te, land	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	Oc. Location - City or	Town, State
Pages nent of profit.	4 Donation 5 Other Specify: Mt. Zion Cemetery 5/1	17/2012 1	Lansdown	e, Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 22. Name and Address of Facility ESTEP Brothers 1300 Eutaw Pla	s Funeral	1 Home,	PA
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ace, Bali	timore, M	D 21217 Approximate Interval
Physician Medical	failure. List only one cause on each line.	or respiratory arrest, s	SHOCK, OF HEAR	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Heroin Intoxication Due to (or as a consequence of):			Dead
'As-1	Sequentially list conditions, b.			
ner				
ted Insit	(Olecase or Injury that initiated events resulting in death). Last Due to (or as a consequence of):			
executed an and all - transitical Ex		10		
be exe		·12 sm		
760 ficate g phys the b	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregram		23d. Date of delivery Month	y Day Year
x 68 h certi rendin use a	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregretary			
b. Box 68760, the death certificate be by the attending physicicled from use as the buring Physician/Medi	Yes 2 No 9 Unknown 9 Unknown			
P.O.			co use contribute to	ably 4 Unknown
duires an sign and be		24a. Was an		topsy findings available
aw recast be a spool		autopsy performed	prior to c	ompletion of cause of
Records, The law requires ficate has been sig spage 2 should be Completed		1 ✓ Yes 2		s 2 No
ician:	25. Was case referred to medical examiner?		sidence 6 Other	
of Vi	1 V Yes 2 No	28d. Describe how		
ath. At the fun	1 Natural 5 Pending fd 5-10-12 unknown	unknown		
VISI or Att fter de pirecte in by t	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Stree	et and Number or Ru	ral Route Number, City ngton Ave.
Division or spital or Attending sours after death, neral Director: After filled in by the funer Certification:	4 Homicide determined (Specify) Found in Dwelling	Baltimore	e,MD.	ngcon Ave.
To the He within 24 To the For the For completed	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of cadifier 29c. License number		Pd. Date signed (Mo	
2	29b. Signature and the of certifier 29c. License number O.C.M.E.		May 11, 2012	, Day, Fear)
TC .	() and I sale I get			
Long	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltim	ore, MD 21223		
State	31. Date filed (Month, Day, Year) 22. Registrar's Signature			
Registra				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sandra ertno 5:00 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 11 MARY CARROLL COURT BALTIMORE 5. Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Hours Min. Country) 216-32-3994 Director 1 M 2 X F 10/16/1935 MD 76 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County with the Maryland aţ Director notified 1 🗆 Yes 2 😾 No MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö must be 23a Funeral 11 MARY CARROLL COURT 21208 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue.
Armed Forces?
Ves 2 No 12. Was Decedent Ever in U.S. 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important; If item 27 is marked other to any injury or other train. Examiner Black, White, etc. þ 1 Never Married 2 XMarried If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MICHAEL ROSENTHAL FRIEDA RUBENSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWIN PERTNOY/HUSBAND MARY CARROLL COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/15/2012 BALTIMORE, MD TIFERETH ISRAEL CEM. : 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Acolo 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant was deceding the past 12 month of the past 12 mont 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes or Attending Physician: funeral director, 25. Was case referred to medica 26. Place of Death (Check only one. Be examiner? Other: Certificate: To 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one

31. Date filed (Month 6 2012

Oncologist

ed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

0056919

Charles

54.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_1	For State Registrar		State of Ma	aryland		artment tificate				giene Reg. No.	201	2	1554
	Physicia		1. Decedent's Name				·				2. Date of De Month May	ath II	, 201		3. Time of Death 1:00 p M
	Medic	al .	Wilma L 4a. Facility Name (if r	ee Quinn	treet and number)			4b. City. To	wn. or Loc	ation of Death	Мау		County of De	_	1:00 P M
الر	Examin	er		at Turf				Ellic					Howard		
	Funeral Director		5. Social Security Nu 491-10-47	mber 6. Sex			st birthday) 95 Yrs.	If Under 1 Months [Jnder 24 Hrs. ours Min.	8. Date of Bir Month, Da NOV • 30	f Birth 9. Birthplace (State or Foreign Country) Nissouri Missouri			
	bow at	_ h	Usual Residence of D	Decedent 10b. County		10c. City	, Town or Loc	cation						100	I. Inside City Limits
	tarylar 3a-f st iified	Director	MD	Howard		Elli	cott C	ity							1 ☐ Yes 2 🙀 No
	a or 2 be no		10e. Street and Num	per				10f. Zip C					izen of What (Country	1?
	th with ms 23 must	11150 Resort Road, Room 321 21042 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - A Black, W											nericar	Indian	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	11. Marital Status1 ☐ Never Marrie3 ☒ Widowed 4	ed 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		f Yes, specify Yes 2			Rican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White).
5-0	hours natura dical E	olete	/Sner	15. Decedent's Educify only highest grace	ucation		16a. Deced	dent's Usual (Occupation	n g most of work	ina	16b. K	ind of Busines	s Indu	stry
21215-0036	thin 72 ne. than "	Completed	Elementary/Seco		College (1-4 or 5	i+)	life. Do	O NOT use re	tired)	g most of work	mig	Ow	n Home		
d 2	led wit Hygie other ent, th	Be C	17. Father's Name (F	Irst, Middle, Last)					18.	Mother's Nam	ne (First, Middle,	Maiden	Surname)		
/lan	d be fill Mental arked artic ev	오	Lewis Reece Cecilia Weber												
Aan	shoul	- 1	19a. Informant's Nar				1	-			al Route Numbe			Zip Co	de)
e,	and 2 Health tem 27		Marilyn 20a. Method of Disp	S. Walter	s/ Daught	20b. P	lace of Dispo	sition (Name	of	TBD	Laurel,	_	ocation - City	or Tow	n, State
mor	Page 1 lent of nt: If ii		1 🖁 Burial 2 🛭	☐ Cremation 3 ☐ I 5 ☐ Other (Specify)	Removal from State			natory or other Natio		Cem.		Arli	ngton,	VA	and the second
Baltimore, Maryland	permit. F Departm Importa any inju	-	21. Signature of Fun		e	1053	- 1				aldson Laurel,			me,	P.A.
	Physician/		Immediate Cause (F	t failure. List only on Final	e cause on each line	9.	n. Do not ente	er the mode o	of dying, su	uch as cardiac	or respiratory a	rrest,		I	Approximate nterval Between Onset and Death Onths
	Medical		disease or condition resulting in death)	•	Dement Due to (or as		ience of):							1111	JIILIIS
	Examiner	Į.	Sequentially list cor	nditions,	b. —		0							-	
	ed	Examiner	if any, leading to im cause Enter Under Cause (Disease or i	lying	Due to (or as	a consequ	ience oi):								
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09	icate be executed physician and s the burial-transit	edical		•	d									+	
687	th certifica ttendi g p or use as t	√Me	IF FEMALE: 23b. Was decedent	pregnant	3c. If yes, outcome								23d. Date of	deliver	ý
. Box 68760	re death or the	Physician/M	in the past 12 n 1 Yes 2X 9 Unknown	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pre☐ Other (spec					Month		Pay Year
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	by	Part II. Other signifi	cant conditions co	ntributing to death b	out not res	ulting in the (underlying ca	use given i	in Part I.					cause of death?
ord	v requi	Completed									24a. Was	an opsy	24b. Were	autops	sy findings available pletion of cause of
Rec	The lay ate has bage 2	mo.									perl	formed?	death	1?	ŊNo
ta	cian: certific ector,	B	25. Was case referre examiner?	h.	lospital: _				_	of Death (Chec			¥		Assisted
j V	Physic r this caral din	<u>ان</u>	1 Yes 2 2 27. Manner of Death	₹NO	1 ☐ Inpat	ıry	28b. Time o	nt 3 DOA f 280	. Injury at	4 Nursing H	lome 5 Res			pecify)	Living
o uc	ath. r: Afte	icate	™X Natural 2 ☐ Accident	5 ☐ Pending Investigation	(Month, Da	y, Year)	injury	М	work? 1 Yes	2 🗆 No					
Division	al or Atte s after de l Directo d in by th	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inj building, et			reet, factory,	office		28f. Location City or To	(Street ar wn, State	nd Number or e)	Rural F	Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the "tendi" g is completed filled in by the funeral director, page 2 should be detached or use as	Medical	(Check 2	X Certifying Phys ☐ Medical Examin ☐ Certifying Nurs	ician: To the best of ner: On the basis of e e Practioner: To the	examination	n and/or inves	stigation, in m	v opinion. c	death occurred	at the time, date	and place	e, and due to t	he caus	e(s) and manner stated
	Vithii Vong	-	29b. Signature and		Suple			29c. l	icense nu 53150	mber		29d. Da	ate signed <i>(Mc</i>	onth, D	
	lom		30. Name and addre	ess of person who c	ompleted cause of										
				ala Gupta					Suite	6, Col	lumbia,	MD :	21045		
	Sta Registr		31. Date filed (Monti	6 2012	32. Hegistr	d. Signa	parke								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM# 10e, per FH, G927, 5, 16/2012, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HUSPITAL BALTIMORE RANDALL NORTHWEST STOWN Social Security Number Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 218.44.765 1 X M 2 - F Months Hours Min. (Month, Day Country) Yrs Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at the Maryland Director Bultimore Locheam MD 1 Yes 2 No 10e. Street and Number Garden 10f. Zip Code 10g. Citizen of What Country? by Funeral Forest Park Avenue 21207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Keligious Pastor 17th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Mark Biddix, Sr. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Garden Avenue Locheam MD Kiddle (WIFE) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 19/2012 Windsor MilliMD 21. Signature of Funeral Service Licensee Vaugnor C. Greene Funeral Services 22. Name and Address of Facility Road Randallstown MD 21133 iberty disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. 23a. Part 1. Enter the shock, or head Approximate Interval Between Immediate Cause (Final Onset and Death ATHEROSCLE CARDIOVASCULAR DISENSE Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE nse yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) To the Hospital or Attending Physician; The law requires that the death for in the past 12 months? Month Year the 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 2 No 3 Probably Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No ☐ Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 2 🔲 No Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatuke and title of certified 29d. Date signed (Month, Day, Year) 2012 0.1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD Ro 401 TKKIN LOVET (AUS) CANDALISTOWN MARYLAND 31. Date filed (Month, Day, Year)

NAY 1 6 2012 32. Registra 's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #1 Per PHY G927 5/29/2012 JH
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5/11/2012 Elizabeth W. Reuling Elizabeth H. Reuling 6:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1206 Tugwell Drive Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 220-22-8217 Director 1 M 2 F 85 2/7/1927 MD Usual Residence of Deced show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director rms 23a or 28a-f shortmast be notified a 1 Yes 2X No MD Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 1206 Tugwell Drive death v items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: Specify: White "natural" Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ဂ္ Lewis Heise Margaret Wintz traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Reuling it of Health a 8101 Laurel Ridge Road; Frederick, MD 21702 other 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Department Important: If any injury or once. New Cathedral Cemetery 5/15/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitSterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Menses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition men Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 DN has page 2 After this certificate 2 **X**No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 16KNatural 5 Pending work death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 24 hours after deatl Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number (Item 23a) (Type, Print) 405 Frederick Rd. # 202, Bold, more, MO 21228 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 2:30 ames W. Rowlan Ам May 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverdale Prince George's 6817 Ingraham Street Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 415-50-4282 Director 1 X M 2 D F 77 May 20, 1934 Maryville, TN "natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Riverdale 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6817 Ingraham Street USA 20737 death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced KOREAN Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Hecht's Repairman Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) should be file.
I and Mental H ೨ Stella Mae Roberts Jesse James Rowland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a ant: If item 27 is 6817 Ingraham Street, Riverdale, MD 20737 Catherine L. Adams / Partner 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 20a, Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1
Burial 2
Cremation 3
Removal from State 5/15/2012 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 la ons /a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Cel Carcinoma year Squamous Medical Due to (or as a consequence of) Examiner 6 months Jaque Italy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical death certificate be Box 68760 ast IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P in the past 12 months? Day Pregnant at time of death Other (specify) Yes 2 No g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should need 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital Other: To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral director. 1 🗌 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1/Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifie

Year 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6492

Landover

29c. License number

Rd

00012015

Cheverly

29d. Date signed (Month, Day, Year) 10-2012

Marela

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 3. Time of Death 2. Date of Death Physician/ MILL Medical institution, give **Examiner** 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Director** -26 Nest 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 No Yes Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 706 eanette Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Sorvice Licensee 22. Name and Address of Facility March FIH-East 1101 E. North Ave, 21202 23a. Part 1. Enter the disease, or complications that ocused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician ascular disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 🗌 No Yes 1 Yes Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) 2 X Hospital Other: 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nersing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗠 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie Transmore Mille 5/14/12 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller Mills Dwings 1525

DHMH 17 Rev 06-2011

State Registrar MA ZIII7

Box

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Marylan State of Marylan Registrar		tificate of E		•	Reg. No.	201	2 1554
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath Day	2012	3. Time of Death
partie.	Medic	al	She1by De11os Reyes 4a. Facility Name (If not institution, give street and number)		4h City Town or	Location of Death			County of Deat	8:10 AM
month	Examin	ier	8502 Pierce Point Court		Potomac				ntgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	ist birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt		9. Birt	hplace (State or Foreign untry)
	Director		556−26−9637 Usual Residence of Decedent 1 X M 2 □ F 89	Yrs.			11-20-		Ca	lafornia
	land show dat	tor	10a. State 10b. County 10c. City	y, Town or Loc	cation					10d. Inside City Limits
	Mary 28a-f ootifie	Director	1101118	otomac						1 ☐ Yes 2X No
	n with the is 23a or	Funeral C	10e. Street and Number 8502 Pierce Point Court		10f. Zip Code 20854				en of What Co ed Sta	
9036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	[출	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ★ No If Yes, Give Year or Dates.		Vas Decedent of His Yes, specify Cubar		ecify Yes or No- Rican, etc.)		4. Race - Ame Black, White pecify: Wh	e, etc.
Baltimore, Maryland 21215-0036	within 72 hou /giene. ner than "nat ner the Medica t, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give k life. DC	lent's Usual Occupa kind of work done d O NOT use retired)		king		d of Business/	Industry
d 2	filed wit al Hygie d other vent, th	Be C	17. Father's Name (First, Middle, Last)	Sales	sman	18. Mother's Nan	ne (First. Middle.			
ılan	should be file and Mental I is marked o aumatic eve	ပ္	Anthony Reyes			Vivian			,	
, Mary	ge 1 and 2 should be it of Health and Men I fitem 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Karen Kuchins — Daughter		g Address (Street a					1and 20854
more	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trae		1 Burial 2 X Cremation 3 Removal from State	emetery, crem	sition (Name of natory or other place Cremator		Date .4-12		ation - City or	Town, State ch, Virginia
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee Edward Sag M00	el 22. 910 l	Name and Addres	s of Facility T	anzansk ce, Rock	y-Gol ville	dberg , Mary	land 20852
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition) Congestive Heart Failure										Interval Between
Physician/ Medical Examiner M										
		iner	If any leading to immediate	ence of:	sease					,
	cuted	xam	cause. Enter Underlying Cause (Disease or injury that initiated events c. Atrial Fibri							
092	cate be executed physician and s the burial-transi	edical Examiner	resulting in death) Last Due to (or as a consequence of the death) Diabetes Me1							
68	ertifica ding pl		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ncy				25	3d. Date of de	liven
Вох	ss that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	Physician/N	1		Ectopic pregnanc Other (specify)	У			Month	Day Year
s, P.O.	res that the signed by do deta	<u>م</u>	Part II. Other significant conditions contributing to death but not resi	ulting in the ur	nderlying cause giv	en in Part I.				the cause of death?
ord	w require s been si 2 should l	Completed					24a. Was		24b. Were au	topsy findings available completion of cause of
Rec	The law ate has page 2	Com					perfo	ormed? 2X No	death?	s 2 □ No
ital	sician: The certificate irector, pag	m	25. Was case referred to medical examiner?		Othe	ace of Death (Chec				
of V	Phys r this eral di	e: To	27. Manner of Death 28a. Date of injury	28b. Time of	t 3 DOA 28c. Injury	4 U Nursing H	ome 5 X Residence 128d. Describe 1			ify)
ion	tending leath. or: Afte the fun	Certificate:	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	injury		? Yes 2 🗆 No				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Fusheral Director. After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (S City or Tow		Number or Ru	ral Route Number,
	n 24 hor n 24 hor e Fune oletely f	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowl	and/or investi	igation, in my opinio	n, death occurred a	at the time, date a	and place, a	and due to the	cause(s) and manner stated.
	To th within To th comp		29b. Signature and title of certifier Frina B Flictman		29c. License	number 52832			signed (Monti	h, Day, Year)
	101		30. Name and address of person who completed cause of death (Item			1 475	26	1 000	070	
	1		Irina B. Sherman, MD - 1396 Pic 31. Date filed (Month, Day, Year) 32. Registrar's Signat		rive, Ro	ckville,	Marylar	nd 208	5/8 	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signat							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5548 Certificate of Death 2. Date of Death Month 2012 May 4b. City, Town, or Location of Death 4c. County of Death Severna Park Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex (Month, Day, Year) Hours 1 □ M 2**X** F 72 02/09/1940 10c. City, Town or Location Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code

1 - For State Registrar Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 1:45 A. M andra Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Genesis Eldercare Severna Park Cen 9. Birthplace (State or Foreign **Funeral Director** 219 36 0357 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State Director filed within 72 hours after death with the Maryland 1 Yes 2 X No Maryland 10e. Street and Number Funeral U.S.A. 21122 8412 Spring Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner, once. ģ 1 Never Married 2 Married Yes 2 X No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 🔀 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fiber Plus Receptionist 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mildred Blanche Boston John Bernard Godwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pasadena, Maryland 21122 Cynthia Kadesuk / Daughter 8412 Spring Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 05/18/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses Baltimore, Maryland 21225 4001 Ritchie Highway complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between nset and Immediate Cause (Final Physicum/ Montho disease or condition resulting in death) Medical Examiner equeritally liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: XNatural 5 Pending s after death.

I Director: Aft set in by the fur 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 5-15-12 ath (Item 23a) (Type, Print) Drive Elkridge, Maryland Marsha 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month ROBERTS 5:30 PM 111LLIAM MAY 2013 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 1ARBOR 1920H TIMORE TAI Social Security Numbe 6. Sex 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 212-28-2950 **XX**M 2 □ F 80 **Director** MD 10-09-1931 Usual Residence of Decedent or 28a-f show notified at Director 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore MD 1

Yes 2 □ No 10e. Street and Number 10f. Zip Code items 23a or ner must be n ö 10g. Citizen of What Country? Funeral 2823 Ganley Dr. 21230 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner anes. Black, White, etc. XX Yes 2 No 1952— If Yes, Give Year or Dates. 1 Never Married 2 Married by Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired, Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer Security 9 Be . Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Roberts Julia Lukeanich 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Mathias / Sister 110 Laurel Ave., Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 05/19/2012 Sykesville, MD Lake View Mem. Park 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Plusician EEDING disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OWEI Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): IGHT DNC attending physician and use as the burial-trai Due to (or as a consequence of): resulting in death) Last or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) g Unknown 9 Unknown P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? after death.

Director: After this certificate I 2 No __ Yes Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 1 Inpatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 Yes 2 No by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, within 24 hours To the Funeral L To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29d. Date signed (Month. Day, Year) MAY MD RES OO Cerdara 2012 100 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

Registrar

State

HARBOR

31. Date filed (Month, Day, Year,

32. Registrar's Signature

· HANOVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 15550 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2012 0615 Sarah Sue Rose May 11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death n/a Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 □ M 2 □ F Days Months Hours 05/30/1925 86 228-28-7950 Yrs Virginia Jsual Residence of Decedent 10b. County 10c. City. Town or Location 10d, Inside City Limits Baltimore 1 X Yes 2 No n/a 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? USA 21202 1014 East Chase Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates. 1 Tes 2 No Specify: Specify: Black 3

▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Household Mamt Domestic Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Gee Fred Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 Guilford Ave #136 Baltimore, MD 21202 Tony Rose - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 05.16.2012 Baltimore, MD Baltimore National Funeral Sen 22. Name and Address of John L. Wil 4517 Park H s of Facility Illiams Funeral Directors, Heights Ave Baltimore, MD At 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final un a consequence of) Due to (or as a consequence of): Due to (or as a consequence of):

permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important if item 27 is marked other the any injury or other trainment. Physician Medical **Examiner**

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Physician/Medical

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29b. Signature and title of certifie

30. Name and address of per

Physician/

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Funeral

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Examiner

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Director

28a-f show

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items death

Medical Examiner

the Maryland

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and the burial attending physician as signed by the at d be detached for been has page 2 After this certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifical director, funeral

The law requires that the death certificate be

P.O. Box 68760

Records,

Division of Vital

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1- Natural 5 Pending injury Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [3 [Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29c. License number

D28487

29d. Date signed (Month, Day, Year, 5/15/2012

To the I within 2

Registrar

State

completed filled in by

RAVEN BLYD 5601 's Signature

on who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Franklin Sanders May 7:30A 2017 Medical 4a. Facility Name (institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5200 Lewellen Avenue Baltimore Gwynn Dak 7. Age (In yrs. last birthday) ear If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Min **Director** 1 X M 2 □ F 1940 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore GWYNN 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code and Mental Hygiene.

Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral ewellen 21207 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Office 12th grade 2 years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည GEOVAE Franklin Sanders, Jr. Phyllis East 19a. Infor 🔷 t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Freedom Avenue Sykesville MD 21784 DUSIN rala 20b. Place of Disposition (Name of cemetery, crematory or other place)
WOCALAWN LIMETERS 20a. Method of Disposition Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 05/17/2012 WoodlawnIND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Licensee 22. Name and Address of Exclisty Valghn C. Greene Fineral Services Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear railure. List only one cause on each line. Immediate Cause (Final Physician) Onset and Death disease or condition resulting in death) ATHEROSCLERO HO cadionermia Directe Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examiner if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): San and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vinknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The law I within 24 hours after death.

To the Funeral Director: After this certificate has E performed? Yes 2 No 2 🗌 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined building, etc. (Specify) . 24 hour. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nume Fractificing: To the best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check death oncurred at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5/15/ N 0 20059056 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saluja 6821 Reimortoun Re MO Balt MS Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Pate of Death 1. Decedent's Name (First, Middle, Last) Physician/ X5 P RIA Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** 2204 Smith Avenue Lansdowne Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-44-9515 Months Days Hours Min. 66 Director 1 ☐ M 2 🔀 F 11/1/45 Yrs PA item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Lansdowne 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' Completed by Funeral 2204 Smith Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 **XX**0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. White If Yes, Give Specify. 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 0 Line Worker GE Be Father's Name (First, Middle, Last)

James Sell 18. Mother's Name (First, Middle, Maiden Surname)
Betty Buterbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2204 Smith Avenue, Lansdowne MD 21227 D. Costigan /Son Roy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 5/10/12 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home 1501 E. Fort Avenue, Baltimore Home, Victor P. Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Due to (or a con uence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Examir the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b lirector, page 2 s autopsy Yes 2 W 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▶ No director, Be 26. Place of Death (Check only one) 9 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this id in by the funeral d 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred injury 1 🔀 Natural 5 Pending Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical within 24 hou

To the Funer

completely fi 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number Plud Sten Burgin 2106, and address of person who completed cause of death (Item State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ MAY Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oila (Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) **Funeral** Hours Director or 28a-f show notified at Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director atonsville 1 Yes 2 No 10g. Citizen of What Country? ō er than "natural", or items 23a or the Medical Examiner must be Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 2 No 1 Never Married 2 Married 1 Yes þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Be 19b. Mailing Address (Street and Number 20a. Method of Disposition Arbutus Memorial Burial 2 Cremation 3 Removal from State 5-18-12 5 Other (Special 4 Donation 21. Signature of Furleral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart ailure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical **Examiner** Jaquerhially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 Yes 2 I 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 N completely filled in by the funeral director, page 2 death? within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA ္ဝ 1 🗌 Yes 2 No 28c. Injury at work? 1 \quad Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Medical Certificate: 27. Manner of Death injury 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 00051865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 MARLES CURTIS 31. Date filed (Month, Day, State Registrar

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, Miles	Medic Examin		4a. Facility Name (if not institution, give street and numb	per)	4b. City, Town, or Locat	tion of Death	4c. County of Death	
Marine.			8615 Trumps Mill Rd. 5. Social Security Number 6. Sex 7	7. Age (In yrs. last birthday	Baltimore of If Under 1 Year If Under 1	County nder 24 Hrs. 8. Date of Bir		imore
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ယ	er dea or iter niner		11. Marital Status 12. Was Deced Armed Force 1 ☐ Never Married 2 🛛 Married 1 ☐ Yes 1	ces?	If Yes, specify Cuban, Mer		14. Race - Americ Black, White,	
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pue	e filed htal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Murry Stem			Mother's Name <i>(First, Middl</i> e, Ethel Tarbart		
Maryland 21215-0036	ould b nd Mer mark matic		19a. Informant's Name/Relationship (Type, Print)	19b Ma		umber or Rural Route Numbe		Code)
Ž,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Donna Derencz (Daughter)	190	5 Lennox Dr.	#79 Eldersbu	rg, Md. 2178	4
Baltimore,	ge 1 ar nt of H it iter or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from S	state cemetery, cr	position (Name of rematory or other place)	Date	20c. Location - City or To	
Ħ	permit. Page 14 Department of H Important: If it any injury or of		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		of Faith 22. Name and Address of F	5-12-2012	Baltimore, Funeral Home	
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- War	Phylician Medical		Immediate Cause (Final disease or condition resulting in death)		al Failus			Onset une Death
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687	ertifica ding p se as t	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ome of pregnancy			23d. Date of deliv	
Вох	leath o e atten id for u	iciar	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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of V	Phys er this eral dii	e: To	27. Manner of Death 28a. Date of		of 28c. Injury at	Nursing Home 5 Resi	dence 6 Other (Specify how injury occurred	()
on (ending sath. or: Afte the fun	ficat	2 Accident Investigation	n, Day, Year) injury	M work? 1 ☐ Yes	2 🗆 No		
Division of Vital Records,	or Att	Certificate:		of Injury - At home, farm, s g, etc. <i>(Specify)</i>	street, factory, office	28f. Location (City or Tov	Street and Number or Rura wn, State)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier 1 Certifying Physician: To the bes					
	To the Ho within 24 To the Fu complete	Mec	(Check only one)		ge, death occurred at the time	e, date and place, and due to	the cause(s) and manner as	stated.
	5 Wit		29b. Signature and title of certifie		29c. License numb	2 1 9	29d. Date signed (Month,	0.40
Ų	x / \ .		30. Name and address of berson who completed cause	of death (Item 23a) (Type	, Print)	~_8	0/27/	~ MD
	80 1		6095 Marshalpe Dr.	Flkridge	MD21079	218 Charles 1	4. Harrien	~ MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2012 Bernice H. Stokes May 10. 10:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Woodbridge Valley Catonsville Baltimore 5. Social Security Number 7. Age (In vrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Days 219-01-0241 Director 1 M 2 X F 96 Aug. 9, 1915 Maryland Usual Residence of Decedent 28a-f show Oa. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Direct 1 Yes 2 K No MD Baltimore Catonsville or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a 107 Bloomsbury Avenue 21228 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces or i Black, White, etc. 1 X Never Married 2 Married Completed by Yes 2 🛚 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White "natural", 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Office Worker Engineering Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Harry Stokes Grace Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 330 Bollinger Road; Littlestown, PA 17340 Gordon Payne-Cousin injury or other 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 5/15/2012 4 ☐ Donation 5 ☐ Other (Specify) n's Cemetery 5/15/2012 Ellicott City, MD
22. Name and Address of Facility Sterling Ashton Schwab Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 St. John's Cemetery 21. Signature of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a co resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown the 1 ☐ Yes 2 € 9 ☐ Unknown P.O. I signed by to ld be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes peen 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law autopsy After this certificate has funeral director, page 2 death? 25. Was case referred to medical 26. Place of Death (Check Be examiner? 1 🗌 Yes 2 ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of De I 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred atural work? 5 Pending death. 2 No Accident Investigation hin 24 hours after deatl the Funeral Director: 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical erlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month -60 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ JOSEDV Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita The Johns 8 Date of Birth 9 Rirthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** (Month, Day, Year) 176-40-4052 Director 1 🖾 M 2 🗆 F Pennsylvania February 6,1950 62 or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland al Hygiene. al Hygiene. d other than "natural", or items 23a or 28a-f shov 10b. County 10a, State Director 1 Yes 2 X No Woodstock Howard Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21163 10782 Folkestone Way 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Medicare Budget Director d 2 should be filed wit alth and Mental Hygie 127 is marked other ir traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Mazzulla Francis Sette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Woodstock, Maryland 21163 f Health (Wife) 10782 Folkestone Way Marcia Sette other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 A Cremation 3 Removal from State 5-17-2012 Glen Burnie, Maryland Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee MOLOSV Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director Attar this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Be | 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Maryland 31. Date filed (Month, Day, Year) MAY 16 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 20b per fb g928 6-12-12 vt State of Maryland / Department of Health and Mental Hygiene 15557 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Keller Suddith May 2, 2012 12:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens at Riderwood Silver Spring Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Hours 226-12-0589 Director 1 🖾 M 2 🗆 F 89 Toms Brook, Virginia February 26, 1923 Usual Residence of Decedent show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location ថ្ម 10d. Inside City Limits Direct Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3116 Gracefield Road, #420 20904 USA ral", or items? death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ρ 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates and Mental Hygiene.
is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dow Chemical 12 Regional Sales Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Madeline Hill DeWitt Suddith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health ar tant: If item 27 is Steven D. Suddith / Son 2712 Accent Court, Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 🛮 Burial 2 🗌 Cremation 3 🗎 Removal from State Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 5-25-12 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAY Roges 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Carciovascular Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Exami that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical Box 68760 the attending pl IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires thin 24 hours after death.

The Funeral Director: After this certificate has been sign mipleally filled in by the funeral director, page 2 should be Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical within 24 hou

To the Fune

completely fi 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D24035 5/2/2012

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year, 32 Registrar's Signature MAY 1 8 2012

Eugenio S. Machado, M.D., 3110 Gracefield Road, Silver Spring, MD 20904

12-03482 Gregory Scribner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 15558 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day May 5, 2012 Medical Examiner 1451 hrs Gregory Scribner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 702 Wicklow Road **Baltimore** 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Min. Hours Director 1 M 2 F Country) 213-62-7447 57 7/26/1954 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importact: If item 27 is marked other than "natural", or items 23a or 23a-f she
injury or other transmite event, the Medical Essainer must be notified at oece. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 Wicklow Road USA Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Black 至 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Security Officer <u>S</u>ecurity 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)

Physician /Medical

Be

Thomas Scribner

Brian Scribner

20a. Method of Disposition

19a. Informant's Name/Relationship (Type, Print)

Examiner

DIVISION Of VITAI RECORDS, P.O. BOX 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending physician and	completely three in by the funeral director, page 2 should be detached for use as the burial - transit
DIVISION OF VITAL TO the Hospital or Attending Physiciae: within 24 hours after death. To the Procent Director: After this certification of the Procent Director.	Modical Cortification: To Bac

3 Suicide

Homicide

29b. Signature and title of certifier

31. Date filed (Month Day Year)

Patricia Aronica-Pollak MD.

6 Could not be determined

30. Name and eddress of person who completed cause of death (Item 23a)

OCME

1	1 X Burial 2 Cremation 3 Removal from State	crematory or other place)	Zee. Zeedlich - Gily or	TOWN, Olato
	4 Donation 5 Other Specify:	Arbutus Mem.Park	5/16/2012 Baltimor	e. Md.
	21. Signature of Funeral Service Licensee	22 Name and Address of Facility Estep Brother 1 1300 Eutaw Pi	rs Funeral Service lace.Baltimore.Md.	PA.
	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	edeath. Do not enter the mode of dying, such as care	diac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. ATTREFOSCIE: Due to (or as a consequence to the condition resulting in death)	rotic Cardiovascular Dis	sease	Death
:	Sequentially list conditions, if any, leading to immediate Due to (or es a consequence)	ence of);		<u> </u>
	cause. Enter Underlying Cause (Disease or injury that initiated c			
	events resulting in death) Last Due to (or as a consequence of the c	ance of):		
		pt.II,27,per me,g927 5-1	18-12 sm	
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death 3 Ectopic p	23d. Date of delivery month D	ay Year
	Part II. Other significant conditions contributing to death but	t not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to to	he cause of death?
	Cachexia		1 Yes 2 No 3 Proba	ably 4 🗹 Unknown
				opsy findings available ompletion of cause of
	25. Was case referred to medical examiner?	26.Place of Death (Ch	heck only one)	
	1 ✓ Yes 2 No	2 ER/Outpatient 3 DOA Other4 N	Nursing Home 5 Residence 6 🗸 Other:	Scene
	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
	Pending Accident Investigation	1 Yes 2 No	0	

20b. Place of Disposition (Name of cemetery,

Betty Scribner

Old Frederick, Catonsville, Md

20c. Location - City or Town, State

28f. Location (Street and Number or Rural Route Number, City

May 6, 2012

29d. Date signed (Month, Day, Year)

Date

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

State

Registra

Assistant Medical Examiner

and manner stated.

acked

28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar	State of Ma	aryland /	,	nent of H cate of D		and Menta		ene g. No. 20	112	155
Physician		Decedent's Name (First, Middle,	Brenda	Smith					te of Death		Year	3. Time of Death 2129
Medica Examine	al -	4a. Facility Name (if not institution, g		Simui	4b.	City, Town, or	Location o	f Death	мау	4c. County o	f Death	2129
4			morial Hospital				Baltime				N/A	
Funeral Director		5. Social Security Number 216-50-3175 Usual Residence of Decedent	5. Sex 7. Age	e (In yrs. last b		Under 1 Year onths Days	If Under 2 Hours	Min. (Mo	te of Birth onth, Day, Y Jan 17, 1	'ear)	9. Birthplac Country)	ce (State or Forei
faryland 8a-f show tified at	ector	10a. State 10b. County	more City	10c. City, To	wn or Location	1	Baltim	ore			10d	. Inside City Limi 1
with the N 23a or 24 ust be no	Funeral Director	10e. Street and Number 2327 North Charles St	treet		10	f. Zip Code	2121	8	10	g. Citizen of Wh	nat Country	?
		11. Marital Status 1 ☐ Never Married 2 ☐ Marrie [*] 3 X Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If Yes,	Decedent of His specify Cubar Yes 2 No	n, Mexican,	in? (Specify Yes Puerto Rican, e	s or No- etc.)		American White, etc.	
thin 72 hounder. Than "nature Medica	Completed by	15. Decedent (Specify only highest Elementary/Secondary (0-12)			Sa. Decedent's (Give kind of life. DO NO	f work done d T use retired)		of working	1	6b. Kind of Bus	iness/Indus	
be filed wif ental Hygie ked other c event, th	as F	12 17. Father's Name (First, Middle, La.	lst) Herbert Brandfo	ord Sr.	-19			r's Name (First,				
2 should lth and Me 27 is mar! traumati		19a. Informant's Name/Relationship	a (Type, Print)	19	_	dress (Street a				ity or Town, Sta		le)
Page 1 and ment of Hea tant: If item jury or other		20a. Method of Disposition 1X Burial 2 Gremation 3 4 Donation 5 Other (Sp		ceme	of Disposition etery, crematory	(Name of or other place	e)	Date May 18, 20		0c. Location - C	ity or Town	
permit. Depart Import any inj once.		21. Son ature of Funeral Service Lig	ense Jagle	1	22. Nan	ne and Addres Estep Bro 1300 Euta	s of Facility thers Fu w Place	neral Servi Baltimore,	ce, P. A. Md 2121	7		
hynici wy Medical		23a. Part Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	oral	VASU			cardiac or respir		t,	In	pproximate terval Between nset and Death
Examiner	١		Due to (or as a	consequence	e of):							<u>.</u>
nd id ransit	Examiner	Sequentially list conditions, if any course to the conditions cause. Enter Underlying Cause (Disease or injury that initiated events	C. Cue to (or es e	nonsequence	a offy							
physician and sthe burial-transit	edical Ex	resulting in death) Last	Due to (or as a	consequence	e of):							
To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Advisor of the funeral director.	Σ	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live Birth 2 Pregnant at 9 Unknown	2 🗌 Fetal dea	ath 3 🗆 Ecto	opic pregnancy er (specify)	у			23d. Date Mont	of delivery h Da	y Year
quires that then signed by ould be detacted	2	Part II. Other significant condition	s contributing to death bu	ut not resulting	g in the underly	ying cause give	en in Part I.	23		cco use contrib		ause of death?
sician; The law re	Completed								a. Was an autopsy performe	ed? pri		findings availabletion of cause o
certific rector,	eg	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	/		Otho		h (Check only or	-			
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate: 10	27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	28a. Date of injury (Month, Day,	y 28b	Outpatient 3 (b. Time of injury	28c. Injury work?	4 □ Nur	28d. De		ce 6 Other		
al or Atte s after de al Directo ed in by th	Series	3 ☐ Suicide 6 ☐ Could no determin		ry - At home, . (Specify)	farm, street, fa	ctory, office			cation (Stre y or Town,	et and Number State)	or Rural Ro	ute Number,
he Hospit lin 24 hour he Funera	Medicar	(Check 2 Medical Exa	hysician: To the best of raminer: On the basis of ex lurse Practitioner: To the	amination and	d/or investigatio	n, in my opinior	n, death occ	curred at the time	e, date and	place, and due t	o the cause	
Vith Con		29b. Signature and title of certifier	dn mo			29c. License	number	2_		d. Date signed (_	(Year)
			m.D. 59	61 N	(Type, Print)	CHAN	19	Street	BA	iltimo	EM	Arylan
State Registrar		31. Date filed (Month, Day, Year) NAY 1 6 20		r's Signature	barks							
MH 17 Rev 06-20	11	11111 40 (8)	No.	-								

ORIGINAL

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		-	For State Registrar	State of Maryland		artment of F tificate of E		Mental Hy	rgiene Reg. No. 20	12 1556
Phys			1. Decedent's Name (First, Middle, Last) BARBARA A	CARTE	8	STANT	00)	2. Date of De Month	eath Day	Year 10:58 M
and and	edica mine	_	4a. Facility Name (if not institution, give stree	t and number)		4b, City, Town, or	Location of Death	1	4c. County o	1 - 1
Fune	ral		SOOD SAMARITAN 5. Social Security Number 6. Sex	HOSPITAL 7. Age (In yrs. la.		BALT!	IMORE If Under 24 Hrs.		N/A	Birthplace (State or Foreign
Direct	tor		213-32-5843 Usual Residence of Decedent	2 V F 7	77 Yrs.	Months Days	Hours Min.	3/31/	7.935	Country) MD
Baltimore, Maryland 21215-0036 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		cto	10a. State 10b. County		Town or Loc					10d. Inside City Limits
the Mar or 28a-	i	Funeral Director	MD Baltimo	re Pa	rkvil	10f. Zip Code			10g. Citizen of Wh	1 Yes 2 No
h with 1 rs 23a nust b		neral	1333 Deanwood Rd	•		2123	3 4		USA	
or item	ı	by Fui		Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No		as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- po Rican, etc.)		- American Indian, White, etc.
0036 urs afte ural", o		ted b	2 Widewed 4 Diversed	f Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		Specify:	Black
21215-0036 within 72 hours after giene. her than "natural", o t, the Medical Exam	-	Completed	15. Decedent's Educat (Specify only highest grade of	ompleted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ation uring most of wor	king	16b. Kind of Bus	iness/Industry
212 I within ygiene. her the		as F	12th N/	College (1-4 or 5+)		ng Assi	stant			
Maryland 2 should be filed Ith and Mental Hy 27 is marked oth traumatic event	, i	90	17. Father's Name (First, Middle, Last) Howard Hill					ne (First, Middle, elma Ca	Maiden Surname)	
fary should and M is man			19a. Informant's Name/Relationship (Type, F				nd Number or Ru	ral Route Numbe	er, City or Town, Sta	
and 2 Health Health tem 27		-	Sonja Stanton-Da 20a. Method of Disposition			Deanwo	od Rd.	Parkvi	ille, MI	21234 Sity or Town, State
Baltimore, ermit, Page 1 and Department of Hes mportant: If item in hijury or othe			1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Kin	metery, crem g Mem	atory or other place	k. 5/14	4/2012	Randal	.lstown, MD
Balt permit. Departi	ouce.		21. Signature of Funeral Service Licensee	6.	22.	Name and Address	s of Facility Ma	arch F/	H-East	1101 E.
		+	23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one ca	on that caused the death.						Approximate
Ptijviria Medic			Immediate Cause (Final disease or condition resulting in death)	CARDIO	ENI	c St	TOCK			Interval Between Onset and Death
Examin	_		resulting in death)	Due to (or as a conseque	ence of):		A/_ T/	VEAR	LTION	J
p ta	Fyaminar		if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	-					
executed an and rial-transit			Cause (Disease or injury that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):					
	100	2 2	d							
Box 68760 death certificate b ne attending physi ed for use as the b	Mo		F FEMALE: 23c. I	f yes, outcome of pregnand	су				23d. Date	of delivery
	Completed by Physician/Medical	SICIA	in the past 12 months?	Live Birth 2 Fetal Pregnant at time of de Unknown	death 3 Lack	Ectopic pregnancy Other (specify)			Monti	
P.O. Both that the desired by the seed detached	A P		Part II. Other significant conditions contribu	uting to death but not resul	Iting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
ords, P.C	t bet	ח ח	HYPERTENSION CORON ARY ART	ATZUNZ	MER	RENAL	かららんだ	1 🗆	Yes 2 □ No 3	☐ Probably 4 ☑ Unknown
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should b	aldmo		CORON ARY ART	ERYDISE	ASE	, DYSLI	PIDEM	A 24a. Was autop	osy prie	ere autopsy findings available or to completion of cause of ath?
Vital Reco ysician: The law is is certificate has to director, page 2 s	Ro C.		25. Was case referred to medical examiner?			26. Pla	ce of Death (Chec	1 Tes		Yes 2 No
f Vit Physic this ce	6	2	1 Yes 2 No	1 Inpatient 2 E	R/Outpatient		4 U Nursing H		dence 6 Other	(Specify)
ion or tending F leath. or: After the funer	icate	Care	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work? M 1 🔲 Y		28d. Describe h	now injury occurred	
or Atter de Directo	Certificate		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At hom bullding, etc. (Specify)	ne, farm, stree	et, factory, office		28f. Location (S City or Tow		or Rural Route Number,
Division To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	Medical		29a. Certifier 1 Certifying Physician	To the best of my knowled	dge, death oc	ccurred at the time,	date and place, a	and due to the ca	ause(s) and manner	as stated.
o the H ithin 24 o the Fl omplete	Me		(Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	ctitioner: To the best of my	and/or investig knowledge, c	death occurred at the	e time, date and pl	ace, and due to t	he cause(s) and mar	
			Sharma	WD		RES	000		29d. Date signed (#	
_		3	0. Name and address of person who comple ABHISHEK SHAR MA	eted cause of death (Item 2	3a) (Type, Pri	IEN BLU	D, BAL	TIMORE	= mD	21239
S Regis	tate		1. Date filed (Month, Day, Year) NAY 1 6 2012	32 Jegis rar's Signatur		res .			•	
Regis	arar		MAI TO ZUIZ	Moreva p	. 14 a	N. 0. 0.				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nunzio Serino 2012 2:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 107-12-3546 1 X M 2 □ F 90 7-25-1921 New York Usual Residence of Decedent 28e-f shov 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Gaithersburg Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 221 Booth St. 20878 United States 2 should be filed within 72 hours after death w th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner my 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No WWII

If Yes, Give Š Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Libro Serino Giovaninna Petrecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Wallace - Daughter 221 Booth Street, Gaithersburg, Maryland 20878 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If its eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery DeWitt, New York 21. Signature of Funeral Service Lipepsee Kurt Blake 22. Name and Address of Facility Danzansky-Goldberg 1170 Rockville Pike, Rockville, Maryland 20852 Fart Filler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastatic Prostate Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the Inneral director, page 2 should be detached for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): attending physician e for use as the burialby Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ASCVD Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DEMENTIA 24a. Was an autopsy performed' RHEUMATOID ARTRITIS 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}}\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 5-13-2012

5 √ State

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

NAY 1 6 2012

Bindu Joseph, MD - 6001 Muncaster Mill Road, Rockville, Maryland 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis rar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	aryland					and N	lental Hy	giene				
	Registrar Certificate of Death Reg. No. 2012											5562				
П	Physicia	in/	Decedent's Name (First, Middle, Jay Lawrence	, ,							2. Date of De		Yan Ye	ear		e of Death
	Medic Examir		Jay Lawrence 4a. Facility Name (if not institution,	Sellers, Jr.			41- 01-	T	1	(D. II	May 11)12 ^Y		10:	55 A M
-	Exami	ler	Gilchrist Cente		re		4b. City, Town, or Location of Death Towson					4c. County of Death Baltimore				
	Funeral		5. Social Security Number (6. Sex 7. Age	e (In yrs. lasi	t birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th	T g		ace (Sta	te or Foreign
	Director		214-02-2568	1 😿 M 2 □ F	43	Yrs.	Months	Days	Hours	Min.	(Month, Da 05/27/	y, Year) 1968		Count		•
	nd how at		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation							14	al locid	e City Limits
	faryla Ba-f s tiffied	Director	Maryland Baltim	ore		ddle		r						"		Yes 2 X No
	the A	قَ	10e. Street and Number				10f. Zij	p Code				10g. Cit	izen of Wha	it Count		
	s 23e	Funeral	1902 Leland Ave	nue				212	220					S.A	-	
	filed within 72 hours after death with the Manyland al Hygiene. 1 other than "natural", or items 23a or 28a-f show went, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Deced Yes, spec	dent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - A			1
36	al", o	d by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give	No				Specify:				Specify:		ite	
21215-0036	hours natura lical E	Completed	15. Decedent			16a. Decede	ent's Usu	al Occupa	ation				ind of Busin			_
215	in 72 e. "nan "	dwc	(Specify only highest Elementary/Seconday (0-12)	grade completed) College (1-4 or 5		(Give k		rk done di	uring most	of worki	ng	10D. K	iliu oi busiii	ess ma	ustry	
21	afiled within 72 hour tal Hygiene. ed other than "natu event, the Medical.	Be C	12			_Disa	bled					Di	sable	<u>d</u>		
Maryland	uld be filed Mental H narked ot natic ever	To B	17. Father's Name (First, Middle, La Jay Lawrence Se	,							e (First, Middle, ean Dav		Su <i>rname)</i>			
Ž	should be and Mei is mark aumatic		19a. Informant's Name/Relationship	<u>`</u>												
Ma	1 and 2 should be fi if Health and Mental item 27 is marked other traumatic ev		Gloria Jean Sell		.)						<i>Route Numbe</i> ltimore					
re,			20a. Method of Disposition	•	20b. Plac	ce of Dispos	ition (Nar	ne of			Date		cation - Cit			
imo	Page 1 ment of ant: If it ary or o		1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp	Removal from State		netery, crem y Hil				05/1	6/2012		timor			
Baltimore,	permit. Page Department of Important: If any injury or once,		21 Signature out uneral Service Lig		5											
ш	ŭ O = @ Ø	4	25			1.	407 (old E	aste	rn A	i Funer venue,	Esse	x, Ma	ryla	ind :	21221
			23a. Part 1. Enter the disease, or conshoot, or heart failure. List on	omplications that caused by one cause on each line	the death. I	Do not enter	the mod	e of dying	, such as o	cardiac o	r respiratory an	rest,			Approxir Interval E	mate Between
~,	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		ucer							- 10		Onset ar	nd Death
تمسية	Examiner		Zooming in dodain,	Due to (or as a	consequen	ice of):										
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequen	nce of):							······	+		
D.	uted id ansit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events													
Tel	execian ar	Ě	resulting in death) Last	Due to (or as a	consequen	nce of):										
200	cate be executed physician and the burial-transit	edical		d										_		
	ath certifica attending p		IF FEMALE:	23c. If yes, outcome of	of programm				-							
Box 68	atten atten for us	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 4 Pregnant at	2 🔲 Fetal d	eath 3	Ectopic p	oregnancy	,			2	23d. Date of Month		y Day	Year
В.	the de	hysi	1 Yes 2 No 9 Unknown	9 🗆 Unknown	time of dea	5 🗆	Other (Sp	ecity)								
Division of Vital Records, P.O.	uires that the dea n signed by the a lid be detached f	by Physician/M	Part II. Other significant conditions	s contributing to death bu	ıt not resulti	ing in the un	derlying o	cause give	en in Part I.		23e. Did to	bacco u	se contribut	e to the	cause o	of death?
ds,	v requires been sig should b	ed									1 🗆 🕆	Yes 2	□ No 3 [Probe	ibly 4	Unknown
COL	aw requi as been 2 should	Completed									24a. Was a					gs available of cause of
Rě	The la	Son									autop perfo 1 Yes	rmed?	deat	h? Yes 2		ii cause oi
tal	s certificate has the sector, page 2 s	Be	25. Was case referred to medical examiner?	Llaamitali				_	ce of Deatl	n (Check	_					, .
Ę	Physi this c	<u>ا</u> ي	1 ☐ Yes 2 ⋈ No 27. Manner of Death	Hospital:					4 ∐ Nui	-	ne 5 🗆 Resid			pecify)	Hosp	bue
n o	ding th. After funer	cate	1 Natural 5 ☐ Pending	28a. Date of injun (Month, Day,	Year)	Bb. Time of injury		8c. Injury : work?	at ′es 2 🗌		8d. Describe h	ow injury	occurred		1	
isio	Atten	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be	v - At home	e, farm, stree	M et, factory		es Z	\rightarrow	28f. Location (S	treet and	I Mumber or	- Rural F	Poute Mu	mhor
Ο	s afte	ပ္သီ	4 - Hornicide determine	building, etc.	(Specify)	, , ,	.,,	,		ľ	City or Tow		rvanibei oi	nurarr	oute rvu	ribei,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	ledical	29a. Certifier (Check 2 Medical Exa	hysician: To the best of n iminer: On the basis of ex	ny knowledo	ge, death oc	cured at	the time, o	date and p	lace, and	I due to the cau	use(s) and	d manner as	stated		
	To the P within 24 To the F complet	≥	only one) 3 L Certifying N	urse Practioner: To the b	est of my kn	nowledge, de	ath occur	red at the	time, date	and place	e, and due to the	nd place, e cause(s)	and due to t and manne	he caus r as stat	e(s) and led.	manner stated.
	5, <u>%</u> 6.8		29b. Signature and title of certifier	lik as	MA		29c.	License	number			29d. Date	e signed (Me	onth, Da	y, Year)	
	۵. ا	-	30. Name and address of person wh	a completed as	# " (Emily	1-1 CT		+41	27		,	May	- //	00	102	
	4		30. Name and address of person wh	670 / N	uin (item 23	sa) (Type, Pri	PLED V	- Lu	it 4	1105	Ball	indo	se M	0 2	120	4
	Stat	е	31. Date filed (Month, Day, Year)	32. egistar	's Signature	, ,,,,	- wer	, 0×					- /			t
	Registra	r	MAY 16	2017 1	. 1	100	a Real	_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For	State of Maryland /	Department of Health and	Mental Hygiene	2012 15563			
	State Registrar		Certificate of Death	Reg. No.				
Physician/ Medical	1. Decedent's Name (First, Middle, L	ast)		2. Date of Death Month Day	Z Year 3. Time of Death 18.30 PM			
Examiner	4a. Facility Name (if not institution, g	ve street and number)	4b. City, Town, or Location of Dea	I'M ANNE ARUNDEL				
Funeral Director	5. Social Security Number 6 220 -68-104\	Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs Months Days Hours Mir Yrs.		9. Birthplace (State or Foreign Country) MARYLAND			
ne Maryland or 28a-f show notified at Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	PO COT GO IA		10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
th the Ma 3a or 28a 1 be notii	10e. Street and Number	POPDET	10f. Zip Code	10g. Citize	n of What Country?			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie	12, Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	. Race - American Indian Black, White, etc.			
5-0036 2 hours after "natural", o idical Exam		If Yes, Give Year or Dates. Education 16a	a. Decedent's Usual Occupation (Give kind of work done during most of wo	Sp. 16b. Kind	of Business/Industry			
21215-003 21215-003 within 72 hours at giene. er than "natural", the Medical Exa	(Specify only highest Elementary/Secondary (0-12)	College (1-4 or 5+)	life, DO NOT use retired)	PA	DUSTRIA!			
Maryland 2 Maryland 2 2 should be filed v Ith and Mental Hyg 27 is marked other rtraumatic event, To Be	17. Father's Name (First, Middle, Las	STON SCOTT		ame (First, Middle, Maiden Su	rname)			
Mary,	19a. Informant's Name/Relationship MARY E. SCOTT.	1 a -	b. Mailing Address (Street and Number or F					
altimore, mit. Page 1 and partment of Head portrant: If item 2 y injury or other ce.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	Removal from State cemet	of Disposition (Name of ery, crematory or other place)	Date 20c. Loca	ation - City or Town, State			
Balti permit. Departr Importa any inju	21. Signature Funeral Service Lice		22. Name and Address of Facility	aughterty bu				
Charactery'	23a. Part 1. Enter the arsease, or control shock, or heart failure. List on Immediate Cause (Final disease or condition	omplications that caused the death. Do y one cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death			
Medical Examiner	resulting in death)	a. Due to (or as a consequence	of: MYS/MHY					
ecuted ecuted and al-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	of):					
te be executed hysician and the burial-transit	resulting in death) Last	Due to (or as a consequence	of):					
certificate certificate use as th	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	th 3 Ectopic pregnancy	23	d. Date of delivery			
O. Box 6876 t the death certificat by the attending pt stached for use as ti	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of death g ☐ Unknown	5 Other (specify)		Month Day Year			
ords, P.O. Box 6876 requires that the death certificat been signed by the attending ph should be detached for use as it		s contributing to death but not resulting	in the underlying cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Unknown			
fital Records, P. sician: The law requires that certificate has been signed lirector, page 2 should be decompleted by				24a. Was an autopsy performed? 1 □ Yes 2 ■ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
tal F clan: T clan: T ertifica ector, p		Heavital	26. Place of Death (Cl					
f Vid Physic this corral dire	1 L Yes 2 L No	Hospital: 1 Inpatient 2 ER/C 28a. Date of injury 28b.	Outpatient 3 DOA Other: 4 Nursing Time of 28c. Injury at	Home 5 Residence 6				
on o	1 Natural 5 Pending 2 Accident Investiga	(Month, Day, Year) tion	injury work? M 1 \sum Yes 2 \sum No	Zod. Booon de non injury				
Division of Vital Records, lat or Attending Physician: The law requires is after cleath. al Director: After this certificate has been signed in by the funeral director, page 2 should be in Certificate: To Be Completed I		ed building, etc. (Specify)		City or Town, State)	Number or Rural Route Number,			
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as it Medical Certificate: To Be Completed by Physician/Mec		aminer: On the basis of examination and	e, death occurred at the time, date and place /or investigation, in my opinion, death occurred owledge, death occurred at the time, date and	ed at the time, date and place, and due to the cause(s	and manner as stated.			
To the with To the comment	29b. Signature and title of certifier	on no	29c. License number	29d. Date	signed (Month, Day, Year) 5 / o 7 / 29 / L			
2	Fe Even,		(Type, Print)	Horne /	S/07/24/2 Mayland 2/225			
State Registrar	31. Date filed (Month, Day, Year) MAY 16	2012 32. Figurar's Signature	pare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Pay 3 28872 Physician/ May 2:30 AM Lea Sirota Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington DC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Country) U<u>kraine</u> **Funeral** Months onth, Day, Year) 02/19/1924 1 M 2 X F 88 Director 213-33-1322 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State Director notified 1X Yes 2 □ No 28a-f Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 must be Completed by Funeral 23a 199 Rollins Ave., Apt. 115 20852 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? "natural", or ite Black, White, etc. 1 Never Married 2 Married Yes 2X No Yes, Give and 2 should be filed within 72 hours after of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. 3 X Widowed 4 Divorced White Year or Dates I Hygiene. other than "natura vent, the Medical E 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unkn. Unkn. and Mental Hygien is marked other tl 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosa Abram Gitelman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 435 Country Club Road, Belleair, FL 33756 Ella Sirota / Daughter In Law 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/16/2012 Beltsville, MD 22. Name and Address of Facility Signature of Funeral Service Licenses Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Pancreatic cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Ordernying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months? Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2. No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No M Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Rd Pockville MD 20852 A : Chilakamarri MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State NAY 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Charlotte Jean Stout 2017 MAG /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number If Under Date of Birth (Month, Day, Year 01/31/1921 7. Age (In yrs. last birthday) If Under 1 Year 9. Birtholace (State or Foreign **Funeral** Months Days Hours 215-18-5404 91 Yrs Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedford Examination was be notified at 10a. State 1X Yes 2 □ No Director Harford Havre de Grace MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 413 Majestic Prince Cir. 21078 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 Automotive Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Howard Burgess Myrtle ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Beverly Ann White / Daughter 413 Majestic Prince Cir., Havre de Grace, MD 21078 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Derota Marshall blotaly Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Done to Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans a consequence of): Due to (or as Box 68760, attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent prognant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ☑ No Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f Ö 9 Unknown <u>~</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 3 Probably 4 Unknown 1 🗌 Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 2 No 1 ☐ Yes 2 DNo Division of Vital 25. Was case referred to medical examiner? 26. Place Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mariner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗹 Natural 5 Pending investigation in 24 hours after death.
the Funeral Director; Aft 1 Yes 2 No 2 Accident within 24 hours after der To the Funeral Directo completely tilled in by th 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month SAUER 10:35 PM (STEORGE 1, 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Cherrywood Reisterstown Futurecare If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Jan 13, Months Hours Min 1933 Maryland Director 79 212-30-5402 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f 1 🗆 Yes 2 😾 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 21136 U.S.A. 12020 Reisterstown Road items ? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. ö à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. If Yes, Give Year or Dates and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Roofer Construction Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Decker Sauerhoff Ellen Elmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 Glenn View Drive Blanco, Texas Daughter Michelle Campbell 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/15/12 Hampstead, MD Carroll Cremation ure of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME 21136 Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner THSLOSC/SLOSIS Sequentially list conditions Examiner cause. Enter Underlying burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Yes detached the 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ELSBROUASCUIAR DEMENTIA Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ENEBRO UPSCULAR 24a. Was an autopsy performed? Yes 2 No has funeral director, page 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 Natural ____vatural
☐ Accident
☐ Sulci 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 🗌 No 24 hours after death. Funeral Director: A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

the

State Registrar only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

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-4	Funeral	1	NORTH OAKS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of E	BALTIMORE 9. Birth 9. Birthplace (State or Foreign
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	and show 1 at	or	Usual Residence of Decedent O 9 10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
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	ith the 3a or t be n		10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath w	Funeral	725 MT. WILSON LANE, #106 11. Marital Status 12. Was Decedent Ever in U.S. 13	21208 . Was Decedent of Hispanic Origin? (Specify Yes or Note of Yes, specify Cuban, Mexican, Puerto Rican, etc.)	USA 14. Race - American Indian,
36	s filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give	1 Yes 2 Xno Specify:	Specific
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e, N	and 2 s Health tem 27		SANDRA SILBERMANN/DAUGHTER 641 20a. Method of Disposition 20b. Place of Disp	0 45TH PLACE, RIVERDALE,	MD 20737 20c. Location - City or Town, State
mor	ent o nt: If y or		1 X Burial 2 Cremation 3 Removal from State cemetery, cri	ematory or other place) FRIENDSHIP 05/15/2012	
Baltimore,	permit. Pag Departmen Important: any injury once.	-			INSON & BROS., INC.
_	⊈∪ = # g			8900 REISTERSTOWN ROAD,	
.116	hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final	no hie Cardiavascul	Interval Between
	Medical Examiner		resulting in death) a. A resulting in death) a. Jet to (or as a consequence of):	TO THE CHYTTON HOLES	as vice ese
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Vita	Physicia this cert ral direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Other:	sidence 6 Souther (Specifical VIP)
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sior	Attend death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	(Street and Number or Rural Route Number,
Divi	tal or after all Dire		4 Homicide determined building, etc. (Specify)		own, State)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	stigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated.
	To the within 2 To the Comple		only one) 3 \(\subseteq \text{Certifying Nurse Practitioner: To the best of my knowledg}\) 29b. Signature and title of certifier	e, death occurred at the time, date and place, and due to 29c. License number	29d. Date signed (Month, Day, Year)
			Hard Nool	D15872	May 14, 2012
	0		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) R/1 Cha	Buparo 21061
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	אשי אטוני מייים	DAKALD - El
*	Registra	ir	MAY 1 6 2012 Come S. park		

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			State Registrar		Cer	tificate of E	Death		Reg. No.	2012	2 15568
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Virginia W.	Taylor				2. Date of De Month	Day	Year	3. Time of Death 2 1 2 5 P M
	Examir		4a. Facility Name (if not institution, give stree Lorien Nursing Co			4b. City, Town, or Colum		n	/	ounty of Death	Howard
	Funeral	Г	5. Social Security Number 6. Sex 166–20–8257	7. Age (In yrs. Ia:	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir		9. Birth Cour	place (State or Foreign
	Director		Usual Residence of Decedent	2,224 90	Yrs.			7/5			PA
	land show	ţō	10a. State 10b. County Howard	10c. City,	Town or Loc	ation Columbia					10d. Inside City Limits
	Mary 28a-f otifie	Director		<u> </u>		COTUINDIA	a 				1 Yes XX No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 6334 Cex	dar Lane		10f. Zip Code	21044		10g. Citize	en of What Cou USA	ntry?
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, Ma	and 2 sho Health an tem 27 is		Donald Taylor	/ Son	19b. Mailin	Address (Street a ctiana Ct	HOMK	osassa F	r, City or To 'lorid	la 3444	
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Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	ictor P. Dox	CLL	Name and Addres arles L. 01 E. For	s of Facility Stevens	Funeral	Home	, Inc.	80
ľ			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	ons that caused the death.						<u> </u>	Approximate
Ĺź	Physician/		Immediate Cause (Final disease or condition		monoi	7 Funk	DOLISM				Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
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	death certificate be executed he attending physician and ted for use as the burial-transit	al Exa	that initiated events c. — resulting in death) Last	Due to (or as a conseque	nce of):						
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687	certific nding I use as	n/Me	IF FEMALE: 23b, Was decedent pregnant 23c. If	yes, outcome of pregnan	cy				22	d. Date of deliv	ion.
Вох	death ne atter ed for	Physician/Me	in the past 12 months?	Live Birth 2 Fetal Pregnant at time of de Unknown		Ectopic pregnancy Other (specify)	ý 		200	Month	Day Year
P.O.	at the d by th	Phy	9 ☐ Unknown Part II. Other significant conditions contribu		ting in the ur	derlying cause give	en in Part I	220 Did to	phonon uno	contribute to t	he cause of death?
	requires that the death certifica been signed by the attending p should be detached for use as	ed by									bably 4 D Unknown
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uc	nding ath. r: Afte ne fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?		26d. Describe II	low injury or	ccuried	
Division of Vital Records,	pital or Attending ours after death. eral Director: After filled in by the funer	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	Be. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	et, factory, office		28f. Location (S City or Tow		lumber or Rura	l Route Number,
	pital o		29a. Certifier 1 Certifying Physician:	To the heat of multipards	dee deeth e		d-4				
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pyan	n the basis of examination a	and/or investig	ation, in my opinior	n, death occurred a	at the time, date a	nd place, an	nd due to the ca	use(s) and manner stated.
	To T		29b. Signature and title of contifier	~ D		29c. License	number		(%)	signed (Month,	
	(0 gm)			ted cause of death (Item 2	3a) (Type. Pr	nt)	/ 1 / /			UJ 30	2012
	7 ()		Hurt (asis	, 334 (eda		ine Co	olembi	a Wa	yw		
	Stat Registra	_	31. Date filed (Month, Day, Year) 6 2012	32. Aegi strar 's Signatur	ba	del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12ay Physician/ 2012 12:55A M Mary Frank Traverson Medical 4c. County of Death **Howard** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Columbia Lorien Nursing & Rehab Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Hours 052-18-6087 **Director** 1 □ M 2 🗓 F New York September 2,1921 90 Usual Residence of De 28a-f show 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2xx No Maryland 1 4 1 Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21042 4990 B-4 Dorsey Hall Drive 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene. Item 27 is marked other than "natural" or itemated Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Associate Editor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4990 B-4 Dorsey Hall Road Ellicott City, Maryland 21042 Deirdre Meschino (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Page 1 cemetery, crematory or other place, 9 1

Burial 2

Cremation 3

Removal from State Department of Important: If any injury or once. May 14,2012 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. W01920 Columbia, Maryland 21045 5555 Twin Knolls Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ___ be detached for Month Day Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy has 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: 2 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28c. Injury at work? 1 \square Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending s after death. 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2

To the I

comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 14, 2012 D47447

DHMH 17 Rev 06-2011

State

Registrar

Andrew Lazris
31. Date filed (Month, Dav. Yea

6

Columbia, Maryland 21044

completed cause of death (Item 23a) (Type, Print)

6334 Cedar Lane

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene												
			- Registral	Certificate of Death	Reg	. No. 2012	2 15570						
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 2012	3. Time of Death						
	Medic	al	Javon A. Tatum 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		8 2012 6 03 A M							
Ž	Examin	er	Union Memorial Hospital	40. County of Death	·								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Baltimore day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	nplace (State or Foreign						
	Director			rs.	May 8,1	982 M							
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 20a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits						
		Director	Baltimore 1X1Ye										
			10e. Street and Number	10g	. Citizen of What Co	untry?							
		Funeral	2919 Mathews St.	21218		USA							
			11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White							
36		d by	1 Nover Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates.	1 ☐ Yes ;:2 ☐xNo Specify:		Specify:Bla	ck						
9	hours natur lical I	lete	15. Decedent's Education 16a. I	Lecedent's Usual Occupation Give kind of work done during most of work	king 16	16b. Kind of Business/Industry							
21,5	iin 72 ie. han " e Mec	To Be Completed		ife. DO NOT use retired)	King								
121	12 should be filed with alth and Mental Hygien 27 is marked other ti r traumatic event, the			aborer	ne (First, Middle, Maid	Rite Aid	de						
anc			17. Father's Name (First, Middle, Last) John Tatum		e Jones	den Surname)							
JZ Z				Mailing Address (Street and Number or Ru		ty or Town, State, Zip	Code)						
Š				19 Mathews St. E									
ore,	of He		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of cemetery	Disposition (Name of , crematory or other place)		c. Location - City or	Town, State						
ij	. Page iment tant: I			ion Cem. May	21,2012	Balto,	Md.						
Baltimore, Maryland 21215-0036	permit. Depart Import any inj once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Calvin B. Scrug	gs Funer	cal Home	21213						
	10-1	Г	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
m (#	hysician/		Immediate Cause (Final disease or condition HYPERKALEMIA										
Medica Examine			resulting in death) Due to (or as a consequence of	f):									
	te be executed nysician and he burial-transit	e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of	n·									
		Examiner	cause. Enter Underlying Cause (Disease or injury	·1·									
		Exa	that initiated events c. resulting in death) Last Due to (or as a consequence of):										
09		dical	d										
876		Mec	IF FEMALE:										
Box 687	th cer ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year							
BG.	hat the deal ed by the at detached fo	iysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown										
Division of Vital Records, P.O.		by Pr											
- S	n sign				1 🗆 Yes	1 🗌 Yes 2 💢 No 3 🗎 Probably 4 🗀 Unknown							
Ö	iw req	Completed			24a. Was an autopsy		topsy findings available completion of cause of						
Rec	The law ate has page 2	Som		performe	performed? death? 1 Yes 2 No 1 Yes 2 No								
ta	sician: The certificate irector, pag	To Be	25. Was case referred to medical examiner?	26. Place of Death (Che	ck only one)								
Ψ	Physi this c ral dir		1 Yes 2 No 1 Inpatient 2 ER/Out	2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
n o	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending placement of the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the funeral director.	cate		jury work? M 1 265 Hijdly at work?	28d. Describe flow litigary occurred								
Sio		Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	m, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Ω̈́			building, etc. (Specify)	building, etc. (Specify)									
		Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
			29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
			> + Changs MD	AT 2438946	AT 2438946 5/8/								
	\ \		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT CHAHAL UNION MEMORIAL HOSPITAL 201 E-UNIV- PKWY BALTIMORE MD										
	Sta Registra		31. Date filed (Month, Day, Year) 32 Aegustrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 05 7012 01 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 12 M 2□F 0 218-08-2745 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Hoatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore, MD MO Director Itimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117-2759 Bend Drive by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Intert 0 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Be F. Brown Kimberly Underdue ပ 19b. Mailing Address (Street and Number or Rural Rout Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Owings Mills MD 21117

20c. Location - City or Town, State Bend Drive Kimberly 2 20a. Method of Disposition Ino ther 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility radicy - Asiton Function 21. Signature of Funeral Service PA, 2134 W, 1/02U. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence if) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1☐Live birth Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown the 9 □Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed certificate 25 Be P After this 27 Certification: death. in by the f

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled

									24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
. Was case referre	d to medical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐ N	' t	Hospital:	1 Inpatient 2	ER/Outpatient	3□।	DOA	Other: 4 ☐ Nu	rsing Ho	me 5 Residence 6	□Other (Specify)
. Manner of Death 1 Natural 2 Accident	5 Pending investigation 6 Could not be determined		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ I	1	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				3f. Location (Street and Number or Rural Route Number, City or Town, State)				
	/	1		_						and manner on stated

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifie,

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Month Margaret Anne Whitesed 10:40 Ам May 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Riverdale 5901 Taylor Road Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Months Davs Hours Min (Month, Dav. Year) 577-34-5300 **Director** 1 M 2 K F 89 Yrs February 6, 1923 Philadelphia, PA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Riverdale 1 X Yes 2 ☐ No Maryland 10e. Street and Number 10f Zip Code 5 10g. Citizen of What Country? ms 23a or must be r Funeral be filed within 72 hours after death with 5901 Taylor Road 20737 USA items. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black White etc. ð 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White "natural" Specify: 3 Widowed 4 Divorced ind Mental Hygiene.
s marked other than "natural umatic event, the Medical Ex Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health Care Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Margaret Cloeren Harry Petersen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12708 Willow Creek Court, Bowie, MD 20720 Thomas S. Petersen / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia 5/19/2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Congestive Heart Failure Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No 5 Other (specify) Month Day Year Pregnant at time of death the g Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 Yes 2 No 2 🛛 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \text{ \text{Other}} \) Other (Specify) 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

24 hours after deal Funeral Director: within 2 To the I

> State Registrar

only one)

29b. Signature and title of certifier

Martin D. Weltz, M.D., 7525 Greenway Center Drive, #205, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) NAY 1 6 2012 Registrar's Signat

Derella

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D23743

29d. Date signed (Month, Day, Year)

5/16/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month W: 11 1an 3:10 **A** M Medical 4b. City, Town, c. Baltinore 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death 2540015 N/A If Under 1 Year If Under 24 Hrs. Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday g. Birthplace (State or Foreign Min. 1 M 2 🗆 F Months Davs Hours Director N.C. 219-30-5543 78 May 11, 1934 Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🔀 Yes 2 🗌 No MD **Baltimore City Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 11 Gorman Avenue U.S.A. ural", or items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes, Give "natural" Specify: Black Completed 3 Divorced 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than Elementary/Seconday (0-12) College (1-4 or 5+) if Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Steel Worker **Environmental Elements** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mabel Williams **Turner Williams** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **Betty Williams** Baltimore, MD 21223 11 Gorman Avenue, Department of Heal: Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State May 18, 2012 Crownsville, Md. 4 ☐ Denation 5 ☐ Other (Specify) Crownsville Veterans Cemetery 21. Signalus Puneral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a Part 1. Fifter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ NEUMON disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner cuertially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami signed by the attending physician and defached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No **Director:** After this certificate has been si in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No ပ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **Natural** injury 5 Pending 1 Yes 2 No death. Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined completed filled Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [the within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar W. RATIMORE

Belti noic

080

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03403 State of Maryland / Department of Health and Mental Hygiene Neilda Lynn Washington 2012 15574 1- For State Certificate of Death Rea. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Da May 2, 2012 1956 hrs Medical Examiner Neilda Lynn Washington 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** 5603 Norwood Avenue Baltimore If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Days Hours Director Country) 1 M 2 XF 43 06/16/1968 MD 219-04-9930 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No Gwynn Oak MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 靣 2212 Lawnwood Circle 21207 USA 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2XX No Yes 1 Yes 2XX No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Charlestown N.H. Housekeeping 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carl S. Washington <u>Angeline</u> <u>Boyd</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Lawnwood Circle, Gwynn Oak, Maryland Angeline Boyd 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State King Memorial Park 5/11/12 Windsor Mill, Md. 4 Donation 5 Other Specify:
21. Signature of Paneral Service License ²² Name and Address of Facility
Estep Brothers Funeral Service, PA
1300 Eutaw Place, Baltimore, Md. 21217 Approximate Interval disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and and Ethanol Intoxication and Cocaine Use Doid (Morphine) Intoxication and Cocaine Use failure. List only one cause on each line /Wiedical Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed AMENDED 23a, 27, 28a-f, per me, g927 5-18-12 sm 23a, per me, g930 8-1-12 sm **X** UNPENDED attending physician or use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Division of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 Other, Nursing Home 5 Residence 6 🗹 Other: Scene DOA this 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural unknown 1 Yes 2 X No 5 Pending Director: fd 9:45 pm fd 5-2-12 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be or Town, State) 5603 Norwood Ave. determined (Specify) Found in Dwelling Baltimore, MD Homicide 29a, Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number May 3, 2012 O.C.M.E.

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Assistant Medical Examiner

2. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

DOME

Victor Weedn MD JD

31. Date filed (Month, Day, Year) NAY 1 6 2012

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 3 40 P M Sharon Warner 12 2012 Mary Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Roseda Square FRANKLIN HOSPITa If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours 212-46-8553 1 □ M 2X F Maryland February 18,1947 **Director** 65 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State aţ irector 1 Yes 2 No injury or other traumatic event, the Medical Examiner must be notified Maryland Essex Baltimore ۵ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA items 23a 21221 471 Wrights Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status S Armed Forces? Black, White, etc. ь 1 Never Married 2 Married ☐ Yes ģ 1 ☐ Yes 2 No Specify. Maryland 21215-0036 Specify: White If Yes, Give "natural", Completed 3 Divorced 4 Divorced Year or Dates Mary 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Law Firm Secretary 12 years Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) should be file.
and Mental F
is marked of Elizabeth Jane Rupert Arnold Wade Minnick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st
Department of Health at.
Important: If item 27 is uny or other 471 Wrights Lane, Essex, Maryland Husband Dudley Warner Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition May Date 17, 1 Burial 2X Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. namere of Funeral Service License withou 21222 complications that caused the dean. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician P. 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death signed by the at 9 I Inknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, been sig Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jafter death.

I Director: After this certificate has the section of the section performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 15-2012 RESODOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUAGE DR Balto md 21237 , Lai MID Horna 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 16 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Tate House - Hospice Of The Chesapeake Linthicum Anne Arundel If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** (Month, Day, Year) 07/06/1952 New York Months Days Min 1 🗆 M 2 🖰 F Director 100-44-9252 59 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 28a-f 1 X Yes 2 No MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 23a Completed by Funeral 407 Hillsmere Drive 21403 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status d other than "natural", or iter event, the Medical Examiner Armed Forces Black, White, etc. 1 X Never Married 2 Married Yes 2 X No and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Lawyer Law 12 5+ and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ of Health and Ments fitem 27 is marked other traumatic e Henry David Walker Margaret Mary McCarthy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Pellegrini / Sister 53 Heathcote Ave, Edison, NJ 08817 Department of Healti Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 5/16/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Dougla L. Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) OCO N Physician/ Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tra Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE yes, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 Yes 22 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy page 2 performed To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA HOSDICE 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injurv 5 Pending s after death. Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one

State Registrar Signature and title of certifier

and address of person who completed cause of

DHMH 17 Rev 06-2011

th (Item 23a) (Type, Print)

32. Registrar's

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State		State	of Marylan				nd Mental H	ygiene	012	15577
	Registra	Name (First, Middle,	l ast)		Cer	tificate of l	Death	2. Date of D	Reg. No. 4	UIZ	10011
Physician/ Medical		Joseph	S.	Wilz				Month	Day	2012	3. Time of Death
Examiner	4a. Facility Na	me (if not institution,		1 1 1	1.	4b. City, Town, o		Death	4c. Coun	ty of Death	4
Funeral	Scrin 7 5. Social Secu		h Med. 6. Sex	T. Age (In yrs. k	ensel ast birthday)	If Under 1 Year	1 If Under 24	Hrs. 8 Date of B	1 13	att	MOVE ace (State or Foreign
Director		1-1251 ence of Decedent	1 X M 2 □ F	95	Yrs.	Months Days	Hours	oct 7	, 1916	Mary	v)
yland f show ed at	10a. State	10b. County		10c. Cit	y, Town or Loc			<u>-</u>		10	ld. Inside City Limits
or 28a- notifi	MD 10e. Street and		timore		Park	ville			10g. Citizen of	5 14 /b = 4 C ==	1 Yes 2 No
death with the Maryland items 23a or 28a-f sho ner must be notified at Elmeral Director	8800	Walther B	lvd.			2123	4		rog. Citizer of	U.S.	*
S = 5 = 2	11. Marital Sta	tus Married 2 Marri wed 4 Divorced	Armed F	2 No	lf If	Vas Decedent of H Yes, specify Cuba		? (Specify Yes or No uerto Rican, etc.)	14. Ra Bla Specif	ace - America ack, White, et fy: Whi t	ic.
15-0036 72 hours after numerical examination in "netural", or ledical examination projected by		15. Deceden	's Education		16a. Deced	ent's Usual Occup			16b. Kind of I	Business/Ind	ustry
21215-0036 21215-0036 within 72 hours after of glene. The Medical Examine, or the Medical Examine. Completed by	Elementary	/Secondary (0-12)	T	1-4 or 5+)	life. DO	ind of work done of NOT use retired) ntractor	_	Working	Bui	i ldin g	
Maryland 2 Maryland 2 2 should be filed w th and Mental Hyg 7.1 is marked othe traumatic event,		ame (First, Middle, La stian	,	Wilz			18. Mother's	Name (First, Middle	e, Maiden Suman Diet		
Maryl Maryl d 2 should alth and M		t's Name/Relationshi		-in-law	19b. Mailin P.O.	g Address (Street Box 116	and Number o	r Rural Route Numb ton, MD	per, City or Town, 21111	State, Zip Co	ode)
Baltimore, Maryland 21215-003 permit. Page 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygene. Impropriant; if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Examone.	20a. Method o 1 🔲 Buria 4 🔲 Dona	f Disposition al 2 X Cremation ation 5 Other (Sc	3 ☐ Removal from	n State C	emetery, crem	sition (Name of atory or other place Serv Cor	· ·	Date 5/15/12	20c. Location	-	n, State
Balti Balti permit. F Departir Importa any inju		of Funeral Service Li			au 22.	Name and Addre	ss of Facility	Ruck Tow Towson,	son Fune	eral Ho	ome, Inc.
	23a. Part 1. E	nter the disease, or or heart failure. List or	complications that	caused the death							Approximate
Physician/ Medical	Immediate Ca disease or co resulting in de	iuse (Final ndition	_a <i>ST</i>	-Elev	ation	1 Myc	can	dial I	n Fac		nterval Between Onset and Death
Examiner			Due to	(or as a consequ	ence of):						
ted ansit	cause. Enter l	Inderlying se or injury	Due to	(úr as a cunsuqu	enee of).						
60-64 ate be executed hysician and the burial-transit	that initiated e resulting in de	events eath) Last	C. Due to	(or as a consequ	ence of):						
6876C pertificate Inding physuse as the Inding physuse as the Inding physuse as the Inding physuse as the Inding Inding Inding Inding Inding Inding Inding India I			d	7.							
	IF FEMALE: 23b. Was dece in the pas 1 Yes 9 Unkr	t 12 months? 2 No	1 Live	gnant at time of d	death 3 🗌	Ectopic pregnance Other (specify)	Sy			ate of deliver onth [y Day Year
P.O. that the ned by e detact		ignificant condition	A	1	1			23e. Did	tobacco use con	tribute to the	cause of death?
ds, duires	COR	onary	Hr	tery	DIS	sease	ಲ	_ 1 □	Yes 2 No	3 🗌 Proba	ibly 4 🗆 Unknown
Recontract The law cate has page 2								24a. Was auto peri 1 🗆 Yes	opsy ormed?	Were autops prior to com death?	y findings available pletion of cause of No
Vital ysician ysician is certifi I director	examiner?	eferred to medical	Hospital:	Inpatient 2	ER/Outpatient	Oth	or.	Check only one)			
n of Ning Phy I. Witer this funeral funeral atte: T	27. Manner of		28a. Date		28b. Time of injury	28c. Injury work	/ at		how injury occur		
Division of V To Attending Phy after death. Director After this d ir by the funeral of Certificate: Te	2 Accide 3 Suicid 4 Homid	e 6 Could no	ot be 28e. Place	e of Injury - At hou ing, etc. <i>(Specify)</i>	ne, farm, stre		Yes 2 □ No	28f. Location	(Street and Numb wn, State)	per or Rural R	Poute Number,
Div To the Hospital o within 24 hours af To the Funeral Di completely filled in	29a. Certifier (Check	2 Medical Ex	aminer: On the bas	sis of examination	and/or investi	gation, in my opinic	on, death occur	ce, and due to the or	and place, and du	ue to the caus	e(s) and manner stated.
To the within To the compl	only one) 29b. Signature	and title of certifier	vurse Practitione	r: 10 the best of m	y knowledge, (29c. License		nd place, and due to	29d. Date signe		
• X/	30 Name and	and Cur	no complete cour	se of death /Itam	23a) (Tupo P		392	45	5/13/	12	inspm.
10.	Gail 31. Date filed (I	Cunnin	gham 32. F	M.D. "	7601	Osler	Drive	e Tows	son Ma	arylai	nd 21204
State Registrar	and the distance of	MAY 16	2012	strar's Signati		ules					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nancy Jane York 2:10 May Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 578-42-4686 **Director** 1 M 2 X F 79 December 19,1932 Washington, DC Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Prince George's Maryland Landover 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral USA 20785 3103 82nd AVenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married 2 X No ģ Yes Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) 12 College (1-4 or 5+) Hygiene. Caregiver traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I Susie Virginia Hudson Paul Jackson Stanley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl Sylvia S. Dodge / Sister 8000 Northumberland Road, Springfield, VA 22153 item 27 other tra 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of F Important: If ite any injury or ott once: cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Riverdale Baptist Cemetery 5/17/2012 Largo, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Interval Between Onset and Death Immediate Cause (Final erclova -Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami ig physician and as the burial-tran that initiated events resulting in death) Last Physician/Medical the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð been signe should be section, altem maen 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop-performed 2 No has page 2 25. Was case referred to medical 1 Yes 2 No certificate Division of Vital director, Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Funeral Director: A etely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

the within To the

State Registrar 29a. Certifier only one)

29b. Signature and title of certifier

Sinah 7600 MAY 1 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Carroll

D0071

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar			tificate of L	Death		Reg. No.	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	1 0	7 -			2. Date of De		3. Tithe Delth 7012 10:00 A.M
	Medic	al	Rona1 4a. Facility Name (if not institution, give street and numb		Zema		Location of Death	May	11 2 4c. County	2012
المحدد	Examin	er	1623 Jackson Street	2.7			imore			N/A
	Funeral Director		218 58 7210 1 M 2 D F	. Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month Da 08/14	th /1951	9. Birthplace (State or Foreign Country) Maryland
	nd how at	J.	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	Aaryla 8a-f s tiffied	Director	Maryland N/A	Ва	1timo	ore				1 X Yes 2 □ No
	with the h s 23a or 2 ust be no	Funeral Di	10e. Street and Number 1623 Jackson Street			10f. Zip Code 2123	30		10g. Citizen of V	What Country?
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Armed Force 11 Never Married 15 Yes, Give Year or Date	es? 2 🗌 No		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		e - American Indian, ck, White, etc. : White
15-0	72 hou "natu ledical	Completed	15. Decedent's Education (Specify only highest grade completed)	1	(Give	dent's Usual Occup kind of work done o O NOT use retired)	ation during most of worki	ng	16b. Kind of B	usiness Industry
212	vithin in items. Items Ithe M		Elementary/Seconday (0-12) College (1-4	or 5+)			stems Ana	lyst	Fede	ral Government
Maryland 2	should be filed v n and Mental Hyg i s marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) Charles	Zeman			18. Mother's Name De1		Maiden Surname arfield	e)
	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Doris Zeman / Wife			ng Address (Street a Jackson	and Number or Rura Street			State, Zip Code) aryland 21230
Baltimore,	Page 1 arment of He tant: If iter		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	cem	Have		erk 06/15		Glen Bu	- City or Town, State
Balt	permit Depart Import any inj once,		21. Sign the of uneral Service Lionnia	re	4	Name and Addres	ss of Facility Gor nie Highwa	ice Fun iy Bal	eral Sentimore,	rvice, P.A. Maryland 21225
	Pnysician/ Medical Examiner	ier	resulting in death) Due to (o Sequentially list conditions,	n line.	₹\$ €		g, such as cardiac c		rest,	Approximate Interval Between Onset and Death Commonwealth
9760	Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. Funeral Director: After this certificate has been signed by the attending physician and ated filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner	Cause (Disease or linjury that initiated events C.	r as a consequen	ce of):					
Box 6	he death certific y the attending r ched for use as	Physician/M	in the past 12 months?	ant at time of deat	eath 3	Ectopic pregnand Other (specify)	sy			ate of delivery onth Day Year
ds, P.O.	v requires that the dea s been signed by the a should be detached f	by	Part II. Other significant conditions contributing to dea	ith but not resulting	ng in the ι	inderlying cause giv	ven in Part I.		obacco use cont	ribute to the cause of death? 3 Probably 4 Unknown
Records,	The law rec cate has bee page 2 sho	Completed							psy ormed?	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?		-	Oth	ace of Death (Check	1.4		
of	ding Phys th. After this funeral dir	sate: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month)	inpatient 2 ER finjury 28 , Day, Year)	l/Outpatier ib. Time of injury	nt 3 □ DOA 28c. Injur work	4 □ Nursing Ho y at	-	dence 6 Oth	
Division	al or Attendi s after death. I Director: A ed in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	f Injury - At home g, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (City or To		er or Rural Route Number,
_	To the Hospital or vivithin 24 hours after To the Funeral Director Completed filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besicn only one) 3 Certifying Nurse Practioner: To	of examination ar	nd/or inves	tigation, in my opinio	on, death occurred at	the time, date	and place, and du	e to the cause(s) and manner state
0	To t With To t		29b. Signature and title of certifier Robert C. Doort.	In		29c. Licenso	number		_	d (Month, Day, Year)
0+	-1		30. Name and address of person who completed cause			Print)	tue. o	x tin		1) 21230
	Sta Registra	e		gistrar's Signature			7100			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Delton John Barbe Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town or Location of Death 4c. County of Death WMHS-RMC mbrek 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jul 24, 1939 9. Birthplace (State or Foreign Country) MD **Funeral** Days Min **Director** 212-38-5025 1 XM 2 □ F 72 Usual Residence of Deceden show 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified 28a-f MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 135 N. Mechanic St. Apt. 510 21502 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 'natural", or 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Completed Korea white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Bar Manager Galen Bar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agnes Anna Martin Henry Delton Barbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code .0 135 N. Mechanic St. Apt. 510 Gladys Barbe wife 27 Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of Department of harmonic little Important: If ite any injury or ot once. 20c. Location - City or Town, State 2 Cremation 3 Figure 15 Other (Specify) 3 Removal from State 5/10/2012 Restlawn Memorial Gardens MD LaVale 22. Name and Address of Eacility Scarpelli Funeral Home, PA nature o Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Fn Approximate Interval Between Onset and Death CORONAR Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten detached for u 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician; The law requires 1 🗆 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 N death? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital 2 🗹 No ဂ 1 Yes Other: After this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify filled in by the funeral Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day. Year)

State Registrar

DHMH 17 Rev 06-2011

200 Gilenn St. Ste. 302 Cumberland, MO 21503

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Kobustiano J. Borrera

31. Date filed (Month, 1914) 1697

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 26, Da 2012 Year Physician/ 11:45 AM Charlotte Billups Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Bowie 15005 Health Center Drive If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 577-40-2489 Director 1 🗆 M 2 🛣 F Sep. 23, 1925|Washington, DC 86 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location be notified at Director 1 X Yes 2 □ No Prince George's Bowie Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö Funeral 23a lusa Examiner must 20715 13060 Marquette Lane 12. Was Decedent Ever in U.S.
Armed Forces

1 ☐ Yes 2 1 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or i Black, White, etc. ģ 1 Never Married 2 Married of filed within refertal Hygiene.

rental Hygiene.

arked other than "natural", or

the Medical Exar Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Health Care 2 should be filed with h and Mental Hygien 7 is marked other the Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Christophine Walker Charles A. Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is, any injury or other traunonce. 13060 Marquette Lane Bowie, MD 20715 Denise Billups/ Daughter 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory of the place) National Cemetery 5/7/2012 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 21. Signature of Funeral Service Licensee - I Kush 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Aspiration Pneumonia disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) death certificate be executed CVA burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Day Year Month ☐ Pregnant at time of death ☐ Unknown signed by the a 1 ☐ Yes 240 g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Ischemic Cardiomyopathy Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DM II Hospital or Attending Physician; The law 24 hours after death.

Funeral Director: After this certificate has I autopsy performed? Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 은 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the Within 2 only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

lhit

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Okeowo Ibitoye,

31. Date filed (Month, Day, Year)

00051437

12200 Annapolis Road Suite 222 Glenn Dale, MD 20769

4/26/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15582 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ APRIL 28, 2012 3:45 AM JACK MEREDITH BURCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TALBOT 8400 INGLETON ROAD EASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 215-28-0409 1 🕅 M 2 🗆 F 79 JULY 19, 1932 MARYLAND Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director be notified MD 1 Yes 2 X No TALBOT EASTON 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral 8400 INGLETON ROAD 21601 USA Examiner must items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) TELECOMMUNICATIONS 12 SUPERVISOR Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname) is marked o ELVA EUGENE ROBERTS CHARLES JOSEPH BURCH, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) je 1 and 2 s t of Health a If item 27 i DAVID B. BURCH, SON 701 BOXMERE COURT, WEST RIVER, MD 20778 Department of Her Important: If it any injur 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4/30/2012 CHESAPEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signally 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 216 23a. Part 1. Enter the disease, or complications naticaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Orophulan Medical Due to (or as a consequence of): Examiner Secure tidly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) The law requires that the death certificate be executed and I-tran. resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 1 Yes 2 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by wearr 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Parkinsons C 1 Yes 2 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Hospital or Attending work? 1 Yes 2 No iniury 5 Pending ours after death.

leral Director: Aft
filled in by the fur 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

19+1 VA PS State

State Registrar (Month PR'3 U 2012 32. Registrar's Signal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ EDWARD BROWN SR. APRIL 29 2012 \mathbf{P}^{M} 3:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3800 ENFIELD CHASE COURT #312 BOWIE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8 Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 579-20-8481 **Director** 1 XM 2 □ F MARCH 10,1926 DC "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD PG BOWIE 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3800 ENFIELD CHASE COURT #312 20716 US 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 A Yes 2 No Black, White, etc 1 Never Married 2 X Married Completed by 72 hours after 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes. Give 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) ENGINEER GOVERNMENT and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOHN BROWN SUSIE VENABLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai CAROLENE BROWN/WIFE 3800 ENFIELD CHASE COURT #312, BOWIE, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5-7-2012 4 Donation 5 Other (Specify) HARMONY MEMORIAL LANDOVER, MD M01653 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Licenses 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the k Phy as 1 use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably A Unknown Completed ESSENTIAL HYPERTENSION 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1X Yes Other: 2 No 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) ဂ 1 Inpatient 2 ER/Outpatient 3 I funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident
3 Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated сотретел 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jocelyne Kouchthou, mi D63748

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

Division of Vital

JOCELYNE KOUATCHOU, M.D. 4041 POWDER MILL RD. BELTSVILLE.

32. Registrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1246 PM lelen 24 Barnhar 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washing 14432 Tollgate Ridge Hancock Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) 217-12-2289 **Director** 1 □ M 2 🗓 F 90 Yrs 03/25/1922 WV Usual Residence of Decede 28a-f shov 10c. City, Town or Location 10d. Inside City Limits aţ 10a. State Director must be notified MD Washington Hancock 1 Yes 2X No 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ō Funeral "natural", or items 23a 14432 Tollgate Ridge 21750 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces?

1 Yes 2 X No þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Rumsey L. Mason Hazel Yonker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shment of Health a tant: If item 27 is Robert J.Barnhart, Jr. / Son 14432 Tollgate Ridge Hancock, MD 21750 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1

Burial 2

Cremation 3

Removal from State injury or Department Important: If any injury or Smithsburg Crematory |05/03/2012 |Smithsburg,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 141 West Main Street Juneral Service Licen M00260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End leans disease or condition Medical resulting in death) Due to (or as a cons Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown the P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 No has certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ after death.

Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Matural iniun 5 Pending 2 Accident Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated eritifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 5 3 2012

State

DHMH 17 Rev 06-2011

Registrar

747 Northern Avenue Hagerstown, MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signa

Barbara Spencer, CNP,

6

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02^{Day}2012 Month 05 9:28 A M Daniel H. Brown Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Elkton, MD 1880 E. Old Philadelphia Pk Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 167-44-1196 **Director** 1 **X**M 2 □ F 12 09 1953 PA58 Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director 28a-f Elkton Cecil 1 Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 1880 E. Old Philadelphia Pike 21921 USA 11. Marital Status Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Armed Force Black, White, etc. ō þ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced W 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Construction Drywaller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H P Chester Brown Jean Purcell other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health ar. Important: If item 27 is a any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mother Jean Brown 994 Hopewell Rd., Oxford, PA Baltimore, 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 05 07 2012 Oxford, PA Oxford Cemetery 22. Name and Address of Facility Edward L Collins, 21. Signature Funeral Service Licensee 86 Pine St Oxford, PA Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ coincek disease or condition Medical resulting in death) consequence of: **Examiner** Sequentially list conditions, Due to (or as a consequence of). ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Unknown 2 No g Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hours after death. uneral Director: After this certificate To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 🗆 Other (Specify) funeral 7. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificates 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and tit

29c. License number

signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 20 | 2 | 1 - State Amend Item 21 per fh,g927,05/14/2012dhb Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Month, Physician/ Patricia Eckols 32 am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner lectica La If Unde 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Hours 238-72-3732 69 Director 1 🗆 M 2 🗶 F GA 02/05/1943 Yrs. Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 X No Waldorf Charles MD oyd, Patricia M41383, Baltimore, Maryland 21215-0036 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20602 Harford Court 2234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces?

1 Yes 2 X No 0 1 Never Married 2 Married Completed by 1 Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) ന്യാ Home Homemaker of Health and Mental Hygie item 27 is marked other other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelaide Betsill ည Cornelia Dennis **Eckols** Truman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2234 Harford Ct. Waldorf, MD 20602 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau George V. Boyd, III, Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenlawn Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Columbia, SC 04/28/2012 4 Donation 5 Other (Specify) La Plata, MD 20646 Raymond Funeral Service, P.A. Signature of Funeral Service Licensee per DVR Michael Raymond 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disense Physician. MUNATH disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death the s 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 perform death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident filled in by the within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title d mo of person who completed cause of death (Item 23a) (Type, Print) enter

Registrar

State

31. Date filed (Month, Day, Year)

MAY 1 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 15587 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Physician/ 25. 2012 a 7:45 A Robert Lee Curtis Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1907 Red Oak Drive Prince George Hyattsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 02/06/1930 Washington, DC 1 X M 2 □ F 82 579-34-7113 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1X Yes 2 ☐ No Maryland Prince George Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 1907 Red Oak Drive 20782 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces? 1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or i ģ 1 Never Married 2 Married . Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. The ment of the ment of the mental "natural", or iury or other traumatic event, the Medical Exami tury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Printer Washington Post Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Orion L. Curtis Gertrude Rice Clatterbuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronce. Robert L. Curtis Jr./Son 1907 Red Oak Dr. Hyattsville MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery |05/01/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice se 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Cart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Bladder Cancer Medical Due to (or as a consequence of) Examiner Prostate Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Examine Due to (or as a consequence of): Cause (Disease or linjury Anemia burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Coronary Artery Disease page 2 s autopsy performed? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending 1 X Natural 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 4 Homicide determined filled in Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

Resa Ghaemian, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one)

29b. Signature and title of certifier

110 Irving St. NW Room 3R-19 Washington, DC 20010

29c. License number

MD31467

29d. Date signed (Month, Day, Year)

04/27/2012

DHMH 17 Rev 7/2009

12-03280 D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Michael Reed DeBosier Joan DiMichele	leath with th r items 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? 14. Never Married 2 X Married Armed Forces? 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Pu	? (Specify Yes or Nuerto Rican, etc.)		White, etc.		Black,
Michael Reed DeBosier Joan DiMichele	hours after of inatural?, or Examiner is	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use					
Revin M. Dean/ Husband 210 Walnut Street, Snow Hill, MD 21863 20c Method of Disposition (Name of cemetery) Date 20c Location - City or Town. State 20c Method of Disposition (Name of cemetery) Date 20c Location - City or Town. State 20c Method of Disposition (Name of cemetery) Date 20c Location - City or Town. State 20c Method of Disposition (Name of cemetery) Date 20c Location - City or Town. State 20c Method of Disposition (Name of cemetery) Date 20c Location - City or Town. State Date	-0036 d within 72 rgiene. ther than "	Complet	12 Homemaker	Name (First, Middle				
The proposed of the proposed o	21215 ould be file d Mental Hy s marked o	æ	Michael Reed DeBosier Joan I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	r or Rural Route N	umber, Cit		, Zip Code)	
22. Signature of Funeral Service Licensee MIChael A. Dean M01129 per DVR MICHAEL A. Dean M01	s l an filter fried frie		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. L	ocation - City or	Town, State	ə
Physician The property of the state of the	Baltimo Department Important: Injury or of	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1/	07.55%	~ Chrost	n 2105	1
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause C	Physician IN coloal		 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Injuries 	liac or respiratory a	irrest, sho	ck, or heart	Approxir Between	nate Interval n Onset and
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The past 12 months? The past	ed nsit	Examin	cause. Enter Underlying Cause (c.issase or injury that initiated events resulting in death). Last Due to (or as a consequence of):					
Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and und	50, te be execut ysician and burial - tra		UNPENDED		230	. Date of deliver		
Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death and und	OX 6876 ath certifical attending ph for use as the	sician/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic principle.	regnancy				Year
24a. Was an autopsy findings aw performed? 1	P.O. By se that the degree by the detached is	Š					_	_
25. Was case referred to medical examiner? 1	ecords, he law require te has been sign 2 should the	mpletec		aut	opsy form <u>ed</u> ?	prior to death?	completion	
27. Manner of Death 1 Natural 5 Pending Investigation 28e. Place of Injury At home, farm, street, factory, office building, etc. 28d. Describe how injury occurred Subject driver of car that was t-boned Subject dri	/ital Ro	å	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other N		Reside	nce 6 Othe	r;	
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State) U.S. Route 113 @ Route 756, Pocomoke City, MD 28g. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 4 Homicide 5 Succide 6 Could not be determined (Specify) Interstate/Express 28g. Place of Injury - At home, farm, street, factory, office building, etc. U.S. Route 113 @ Route 756, Pocomoke City, MD 28g. Location (Street and Number or Rural Route Number or Town, State) U.S. Route 113 @ Route 756, Pocomoke City, MD 29g. Certifier (Check only one) 29g. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29g. Signature and Number or Rural Route Number or Town, State) U.S. Route 113 @ Route 756, Pocomoke City, MD 29g. Signature and Number or Rural Route Number or Town, State) U.S. Route 113 @ Route 756, Pocomoke City, MD 29g. Signature and Number or Rural Route Number or Rural Route Number or Rural Route Number or Town, State) U.S. Route 113 @ Route 756, Pocomoke City, MD 29g. Signature and Number or Rural Route Number or Ru	ion of V tending Ph, eath. ior: After th		27. Manner of Death 1 Natural 5 Pending Apr 27, 2012 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 1558 hrs 1 Yes 2 ✓ No.	o Subject dr	iver of o	car that was		
29b. Signature and title of certifier 29c. Lefting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Divis spital or At tours after d acral Direct filled in by	Certific	3 Suicide 4 Homicide 6 Could not be determined	U.S.Route 1	State) 13 @ R	oute 756, Poc	moke Cit	
	To the Ho within 24 b To the Fu		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	e, and due to the ca	te and pla	ice, and due to th	ne cause(s)	
O.C.M.E. April 28, 2012		2	Victo Valler Velet O.C.M.E.				, = 30, 10	
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Balt	timore, MD 21	223			
State Registrar DHMH 17 Rev 1/2001 OCME ORIGINAL			MAY 0 2 2012 Bene A. Bake					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Physician/ 26 2012 11:58 P M April Robert Merrell Dunlap Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Harwood 4315 Warthen Drive . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours 11/28/1929 Director 175-22-1605 82 1 🗓 M 2 🗆 F Pennsylvania Show 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Anne Arundel Harwood Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20776 4315 Warthen Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced 4 Divorced Completed Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction 12 Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Suess Merrell Dunlap 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Warthen Drive, Harwood, Maryland 20776 19a. Informant's Name/Relationship (Type, Print) Shirley Dunlap/Wife ge 1 and 2 sint of Health at 1 item 27 i other 3altimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Kalas Crematory Department of Important: If it any injury or conce. 1 Burial 2 X Cremation 3 Removal from State 04/29/12 Edgewater, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MACREL disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter oncenying Cause (Disease or injury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death been signed by the a should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No After this certificate Hospital or Attending Physician: 24 hours after death.

Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No 은 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) completely filled in by the funeral 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License numbe 29b. Signature and title of certif

Harvey J. Steinfeld, 6131 Shady Side Road, Shady Side, Maryland 20764

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registra

Marve

31. Date filed (Month

D05158

04/27/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SUSAN MARIE DAVISON 20 2012 APR 1:06 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WALTER REED NATIONAL MEDICAL BETHESDA MONTGOMERY 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Days Months Min. January 14,1956 56 **Director** New Jersey 149-48-7037 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Virginia Fairfax Burke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9222 Byron Terrace 22015 within 72 hours after death Armed Forces?

1 X Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Black, White, etc permit. Page 1 and 2 should be filec within 72 hours .fter c Department of Health and Mental Hygiene. Important: If item 27 is marked of Ler than "natural", or i any injury or other traumatic event, the Medical Examin 1 Never Married 2 X Married <u>چ</u> Maryland 21215-0036 If Yes, Give Year or Dates. 1982 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse U.S.A.F ŏ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard J. Davison Anita Doscher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duane Murphy Husband 9222 Byron Terrace, Burke, Virginia 22015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of National ry. Panetex prother place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) 4/30/2012 Home Crematory Falls Church, Virginia 21. Signature of Puperal Service Licensee 22. Name and Address of Facility Murphy Funeral Home ikui. MO1343 1102 W. Broad St. Falls Church, Virginia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phylician METASTATIC BREAST CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 Xo 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 🛣 No 1 Yes 2 No Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 💢 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Division Accident Investigation ☐ Accider☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mly one) 29c. License number

State Registrar TOWELL AND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS F. POWELL,

NE 24489

BETHESDA, MD 20889

WALTER REED NATIONAL MEDICAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15591 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ NATHANIEL DIXON $10:00_{A}^{M}$ APRIL 28 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** SILVER SPRING MONTGOMERY 2201 COLSTON DRIVE #810 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Yea MARCH 3, Country) 1 X M 2 □ F 1919 DC Director 577-16-6792 93 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. Count 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 ▼ Yes 2 No SILVER SPRING MONTGOMERY MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20910 2201 COLSTON DRIVE #810 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2X No ð Maryland 21215-0036 1 Yes 2 No Specify BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) FEDERAL GOVERNMENT 5 BUDGET ANALYST Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental H .. Page 1 and 2 should be file truent of Health and Mental tant: If item 27 is marked of jury or other traumatic eve HELEN E. HUGHES WILLIAM H. DIXON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2821 O STREET, SE, WASHINGTON, DC 20020 GARY DIXON/SON Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDALE PARK CREMATORY 5-2-2012 4 Donation 5 Other (Specify) RIVERDALE, MD 21. Signature of Funeral Service Acensee 22. Name and Address of Facility POPE FUNERAL HOMES, P. 5538 MARLBORO PIKE, FORESTVILLE, MD 20746 -ax MULOFY Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ISCHEMIA CARDIAC ARRHYTHMIA Medical Examiner Sequentially list conditions, Examine Due to for as a consequence UI if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical death certificate be Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day for Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown a Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed be de ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? or Attending Physician: The law page 2 has performed? Yes 2X 2 No. 1 Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2**X** No ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No iniury 1 XNatural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Certifying Nuise Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

19

JOHN HUDSON-ODOI 15245 SHADY GROVE ROAD, ROCKVILLE, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year

R169951

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret Davis Eisenhauer 28. 2012 10:30 AM April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ashton 17717 Tree Lawn Drive Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Month, Day, 1 □ M 2 🖾 F Months Hours Min 220-34-3226 73 **Director** 938 Coatesville, PA June Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Ashton Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 20861 17717 Tree Lawn Drive USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Prince George's al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide e 1 and 2 should be filed w of Health and Mental Hygik of Health and Mental Hygik If item 27 is marked other ir other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Knowles Cooper Anne Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell H. Eisenhauer / Husband 17717 Tree Lawn Drive, Ashton, MD 20861 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) if it 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State permit. Page Department of Important: If any injury or 4/30/2012 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rogers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Phu i ian Coronary Artery Disease disease or condition resulting in death) Years Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate

Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Renal Failure, Aortic Valve Replacement, 1 Tes 2 No 3 Probably 4 X Unknown Completed has been Congestive Heart Failure, Respiratory Failure 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician; The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performed' 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify, ပ္ 1 Tyes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending (Month, Day, Year) work' Accident 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) D18726 4/30/2012

DHMH 17 Rev 7/2009

State Registrar $m{z}$ hur Schoengold, M.D., 18111 Prince Philip Drive, T-10, Olney, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De			ental Hyg	giene		
			State Registrar	Certificate of De	eath		Reg. No. 2	012	15593
	Physicia	n/	1. Decedent's Name (First, Middle, Last)			2. Date of Dea April	24 ^{Day} 20	. Year	3. Time of Death
	Medic	al	Theola Lee Watson East	T. a. z	Van af Baath	Apr ₁₁			9:37 P M
)	Examin	er	4a. Facility Name (if not institution, give street and number) Holy Cross Medical Center	4b. City, Town, or Lo			4c. Count Mon	tgome:	ry
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year I	-	8. Date of Birt		9. Birthp	lace (State or Foreign
	Director		579-28-7316 1□M2XF 95 Yrs		Hours Willi.	03/28/			h Carolina
	how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location					0d. Inside City Limits
	laryla 3a-f s iffied	ecto	Maryland Montgomery Wheaton	n					1 🙀 Yes 2 🗌 No
	the N or 28	ä	10e. Street and Number	10f. Zip Code		T	10g. Citizen of	What Cour	try?
	s 23a	Funeral Director	901 Arcola Avenue	20902			U.S.A	•	
	death r item iner n		Armed Forces?	 Was Decedent of Hisp If Yes, specify Cuban, 	anic Origin? (Sped Mexican, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ck, White,	
200	al", o	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates,	1 ☐ Yes 2 🕱 No	Specify:		Specif	Bla	ck
213-003o	hours natur lical I	Completed	15. Decedent's Education 16a. De	ecedent's Usual Occupation		og.	16b. Kind of E		
Z	nin 72 ne. han " e Mec	omp	Elementary/Secondary (0-12) College (1-4 or 5+)	e. DO NOT use retired)	ing most of worki	ig	_		
7	d with hygier ther t	Be C	10 Ho	ousekeeping	8. Mother's Name	(Fired Mindella		mesti	<u>c</u>
and	be file antal F ked o c evel	To E	Robert Lee		Eucie F		iviaideri Surriari	(e)	
37	ould I nd Me s marl			Nailing Address (Street and			r, City or Town,	State, Zip (Code)
Ma	d 2 shalth a alth a 27 is		Robert J. Watson/Son 6	500 Acorn Ct	. Temple	Hills	MD 20	748	
o e	of He		20a. Method of Disposition 20b. Place of D	isposition (Name of crematory or other place)		ate	20c. Location		wn, State
Ě	Page tment tant: I			n <u>coln Cemete</u>					
baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	22. Name and Address					
			23a. Par 1. Enter the disease, or complications that caused the death. Do not	anter the mode of dying,				MD 20	Approximate
	hysician/		Shock, or heart failure. List only one cause on each line.						Interval Between Onset and Death
	Medical		disease or condition resulting in death) Coronary Artery Due to (or as a consequence of):	Disease				+	
7	Examiner	L	Sequentially list conditions, b.						
	n #	nine	if any, reading to immediate 200 cause. Enter Underlying						
	ecuter and -trans	xan	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					-	
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	locating in total years						
2/00	ficate g physas the	Aedi	_ u						
100)	For Attending Physician: The law requires that the death certificat after death. Jinector Atter this certificate has been signed by the attending phy birector. The funeral director, page 2 should be detached for use as the funeral director.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live Birth 2 □ Fetal death	3 Ectopic pregnancy				ate of deliv	
POX	death he att	sici	in the past 12 months? 1 \(\text{Yes} \) 2\(\text{XS} \) No 9 \(\text{Unknown} \) Unknown 9 \(\text{Unknown} \) Unknown	5 Other (specify)			l M	onth	Day Year
л. Э	at the d by t detack		Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause giver	n in Part I.	23e. Did to	obacco use cor	tribute to th	ne cause of death?
ν, Τ	signe d be c	d by				1 🗆	Yes 2 □ No	3 Pro	pably 4X Unknown
	requi been shoul	Completed				24a. Was	an 24b		osy findings available
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Vital Records,	ian: Ti rtifical stor, p	ø	25. Was case referred to medical	26. Plac	e of Death (Check		2 13/1101	1 🗀 163	2 🗔 140
<u> </u>	hysici nis ce Il direc	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ▼ ER/Outp		4 Nursing Ho	me 5 🗆 Resid	dence 6 🗌 Ot	ner (Specify)
101	ing P	ate:	27. Manner of Death 128b. Tim 28b. Tim (Month, Day, Year) 28b. Tim (inju	ry work?		28d. Describe h	now injury occur	red	
SIO	ttend death stor: / y the i	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		es 2 No	28f Location (5	Street and Num	ber or Rum	Route Number,
DIVISION	after after Direct		4 Homicide determined building, etc. (Specify)	, stroot, ractory, onles		City or Tou		301 01 1 lara	Troute Trampon,
	ospita hours uneral ly fille	edical	29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, de	ath occurred at the time,	date and place, ar	nd due to the ca	ause(s) and mai	ner as stat	ed.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	(Check only one) 3 Certifying Nurse Practitioner: To the best of my knowle	edge, death occurred at the	time, date and pla	ce, and due to t	the cause(s) and	manner as	stated.
			29b. Signature and the of certifier	29c. License r			29d. Date sign		
	2		Julia Suray	D5669)1		April	25, 2	012
	P		30. Name and address of person who completed cause of death (Item 23a) (Tyle Dr. Sultana Ghousia 1500 Forest Gles		Sprine.	MD 20	910		
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signatus	LIGO DIIVEI	. UPLINS	, 20			
	Registra	ar	MAI O 3 COIL CAMES A. 17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2012 May Physician/ 9 1:15A M ARLENE E. ESPEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford White Hall Sunshine Acres 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1/5/1923 216-20-4690 WV Director 1 □ M 2 💢 F 89 Usual Residence of Decedent 28a-f show items 23a or 28a-f sho her must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Forest Hill Harford MD 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21050 USA 2265 Phillips Mill Road death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceuent 2... Armed Forces? 1 Yes 2 No 14 Race - American Indian. ı "natura!", or iten edical Examiner ı Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be 1. Department of Health and Mental Important: If item 27 is many injury or other any injury or other permits and permits an ပ Nancy Wamsley Gilbert Brock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 050 19a. Informant's Name/Relationship (Type, Print) Nancy Yeager/Daughter 2261 Phillips Mill Road, Forest Hill, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air M.Garden 5/11/12 Bel Air, MD Signature of Fale A Servi 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA17314 Rovert Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Il or Attending Physician: The law safter death.

Director: After this certificate has filled in by the funeral director, page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Medical Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a 🕠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Signature and title of certifier 29c. License number 29d. Date sidned (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 9:03 PM Physician/ Thomas Francis Ford, Sr. phi Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HOSPITAL _dure Prince George's Regional Laure Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** Days Hours 5/22/4947 64 **Director** |579–62**–**1898 1 🗙 M 2 🗆 F 10c. City, Town or Location 10d. Inside City Limits 28a-f show 10a. State death with the Maryland must be notified at Director 1 XYes 2 No Laurel MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō iral", or items 23a Examiner must be Funeral USA 20723 10131 Washington Blvd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 No 1971 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Specify: Black 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced 1971 ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) f Health and Mental Hygiene. item 27 is marked other tha other traumatic event, the N Private Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edmonia Hawkins ပ Robert C. Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15750 Millbrook Ln Laurel, MD 20707 Meghale Ford/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Department of H Important: If ite any injury or ot once. cemetery, crematory or other place)
Maryland veterans Cemetery, 5/9/2012 1 Burial 2 Cremation 3 Removal from State Cheltenham, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral MD 20601 2294 Old Washington Rd Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Myocardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 \(\simeg\) Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death injury 1 Natural 5 Pending Investigation Accident 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier | Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, 29c. License number 29b. Signature and title of certific '/Y M 7300 Van Dusen Rd. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BY, X

DHMH 17 Rev 06-2011

Registrar

Laurel Regional

Shapiro

31. Date filed (Month.

Hospital

Emergency

20707

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Ruby Doris Gibson April 28, 9:43 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c, County of Death Landover Hills Prince George's 7119 Allison Street Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours 578-42-0489 **Director** 1 🗌 M 2 🔀 F 79 Yrs January 19, 1933 Clinton, NC Usual Residence of Decedent Show 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director Landover Hills 1 X Yes 2 No Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7119 Allison Street 20784 IISA Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates White "natural", Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Prince George's (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) School Cafeteria Manager County School 11 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o Annie Oleta McKenzie Kirk Payne Spell of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Gibson, II / Son 8725 C Street, Chesapeake Beach, MD 20732 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If its any injury or ot 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/5/2012 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue lonstane Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Jase 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of): Examiner Lung Cancer 4 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Chronic Obstructive Pulmonary Disease Division of Vital Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnods peen Were autopsy findings available prior to completion of cause of Hyperlipidemia 24a. Was an page 2 s has autopsy performe death? After this certificate 1 ☐ Yes 2 🔀 No 1 Yes 2 No Hospital or Attending Physician: ²⁴ hours after death. Funeral Director: After this certifics 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No X Natural Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50951 5/1/2012 10

Registrar

DHMH 17 Bev 06-2011

D

M.D., 6510 Kenilworth Avenue, Suite 2400, Riverdale, MD 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reva Saini Gill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of N	Maryland	/ Depa	rtment of F tificate of D	lealth Death	and M		_	2012	2 155	98
			Registrar 1. Decedent's Name (First, Middle	Last)		007	inouto or E	Journ		2. Date of De			3. Time of De	eath
	Physicia Medic		Melvin A. Gilke	s						Month 4	28	2012	12:17	\mathbf{p}^{M}
	Examin	er	4a. Facility Name (if not institution,	,)		4b. City, Town, or					inty of Deat		
مجلتها	Funeral		Sunrise Of Silv 5. Social Security Number		Age (In yrs. last i	birthday)	Silver If Under 1 Year		ng er 24 Hrs.	8. Date of Bird		gomer:	y hplace (State or Fi	oneian
	Director		578-36-7665	1 🖾 M 2 🗆 F	10	Yrs.	Months Days	Hours	Min.	(Month, Da		Cot	untry)	Ü
	nd at	Į.	Usual Residence of Decedent 10a, State 10b, County		10c. City, To		ation	1		12 14	+ 191	l New	7 York, N	
	arylar la-fst	ecto											1X Yes 2	
	the M or 28 e not	ρij	DC 10e. Street and Number		wasn	<u>ingto</u>	10f. Zip Code				10g. Citizen	of What Co	untry?	
	s 23a	Funeral Director	1412 Sheridan S	treet NW			20011				United	1 Stat	es	
_	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	11. Marital Status 1 ☐ Never Married 2 ※ Marr	12. Was Deceden Armed Forces 1 Yes 2	t Ever in U.S.	lf	as Decedent of Hi Yes, specify Cuba	n, Mexica	an, Puerto F	cify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.	
2-002p	ural", o		3 Widowed 4 Divorced	If Yes, Give Year or Dates.	_ 100	1	☐ Yes 2 [™] No	Specif	fy: 		Spe	cify: Bla	ıck	
2	72 hou "nat Fedica	Completed		t's Education st grade completed)	1	(Give k.	ent's Usual Occupa ind of work done d) NOT use retired)	ation <i>luring m</i> o	st of workir	ng	16b. Kind o	of Business/	Industry	
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yland	filed tal Hyged of other event.	To Be	17. Father's Name (First, Middle, L	,				18. Mot	her's Name	(First, Middle,	Maiden Sum	a <i>m</i> e)		
7	ould be d Men marke natic	_	Clarence C. Gi. 19a. Informant's Name/Relationsh		- OT					llinse				
Z Z	12 shouth and the sho		Jonathan Quande:			,	g Address (Street a Dudley C					n, State, Zip	Code)	
baitimore,	of Hear of Hear fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	_	20b. Place	e of Dispos	sition (Name of atory or other place			ate		on - City or	Town, State	
Ĕ	t. Page tment tant: I		4 Donation 5 Other (S	pecify	Fort	Line	oln		5-7-2				Maryland	d
n n	permi Depar Impor any ir		21. Star atural f Funeral Servic L	1 100	01592		Name and Address 12th							
- Sign	Physician/		23a Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each li	ne.	o not enter		g, such as	s cardiac or	r respiratory ar			Approximate Interval Betwee Onset and Dea	
The state of the s	Medical Examiner		resulting in death)	Due to (or a	s a consequent	ce of):	didiovas	cara	I DIS	Casc			years	
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	xecute	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	ce of):								
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S S S	: The law cate has ; page 2		_Failure To Thr	ive						autor	osy ormed?	prior to death?	completion of caus	se of
NI G	sician certifi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	atient 2 🗆 ERA	/Outbrookings	Otho		ath (Check		o 55	211	Assiste _{fy)} Living	d
5	ding Phy h. After this funeral o		27. Manner of Death 1 A Natural 5 Pending 2 Accident Investion	28a. Date of in (Month, D	jury 28I	b. Time of injury	28c. Injury work	at	2	8d. Describe h			(y)H 1 V 111	
DIVISION OF	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 ☐ Accident	not be 28e. Place of Ir	njury - At home, etc. (Specify)	, farm, stre	et, factory, office	103 2 2		28f. Location (S City or Tow		mber or Rui	ral Route Number,	
-	he Hospitt in 24 hours he Funera pletely fille	Medical	(Check 2 Medical E.	Physician: To the best of caminer: On the basis of Nurse Practitioner: To	examination an	d/or investi	gation, in my opinio	n, death c	occurred at	the time, date a	ind place, and	due to the o	ause(s) and manne	r stated.
_	To the with		29b. Signatur and title of certifier	manda	۱۸,		29c. License				29d. Date siç		, Day, Year)	
	02		30. Name and address of person v			a) (Type, Pr	D 533	υ/ —			5-1-	2012		
			Shyamsundar Raj	an 9801 G	eorgia .	Ave.		1 Si	lver_	Spring	MD. 20	0902		
	Stat Registra		31. Date filed (Month, Pay, Year) NAY 0 32012	32. Degis	trar' Signature									

amend 20b, per fh, g927 5-16-12 sm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 31, per DVR, g927 5-16-12 sm

State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 5:26A M Physician/ GENEVIEVE RUBY GALLAGHER MAY 1,2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner CALVERT PRINCE FREDERICK CALVERT NURSING CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Day, Year) 21 W.VA 234-26-3379 1 □ M 2 🏋 F **Director** 91 Yrs. 28a-f show 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho 10a. State Director Examiner must be notified 1 XYes 2 □ No MD. PRINCE FREDERICK CALVERT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20678 U.S.A. 85 HOSPITAL ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FRANKIE PAULINE PARRISH OTTO HAROLD HAWK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3289 CAPTAIN DEMENT DR. WALDORF, MD. 20603 19a. Informant's Name/Relationship (Type, Print) NORITA K. PARK-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARLINGTON NAT.CEM: 5/14/2012 ARLINGTON, VA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
I.A PLATA, MARYLAND 20646 Signature of Funeral Service Licensee M00479 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mini disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 1 🗌 Yes this certificate 1 Yes 2 funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After work?
1 Yes 2 No injury Natural 5 Pending Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 29b, Signature and title o completed cause of death (Item 23a) (Type, Print) 30. Name and address of person y Allentown Rd. #500 nd. 20746 580 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 29°, 2012 9:35 **P** M Theresa Housley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing & Rehab Crownsville Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) PA 1 □ M 2 😾 F 187-18-5566 91 Yrs 0771671920 Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 💢 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 235 B Boxwood Rd #107 21403 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black. White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: White Completed 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Caretaker Church traumatic event, filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Francis Mary V. Saunders Dougherty 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 235 B Boxwood Rd #107 Annapolis, MD 21403 David Housley (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/30/2012 Glen Burnie, MD Signature of Funeral Service Acensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause or Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sequence of) as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth 2 Live Sirth 4 Pregnant at time of death that the death in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No 2 **N**ONo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work?
1 Yes 2 No injury 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) eath (Item 23a) (Type, Print) in Hwy Sw

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

amend 12,per fh,g927 5-29-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depart		Mental Hygie	ne 2012 1560
			Registrar Certifi	icate of Death	1	. No.
	Physicia	n/	Oscar Martin Harvey		Date of Death Month	Day Year 24 2012 10:16A M
	Medic Examin			o. City, Town, or Location of Deatl	April	24 2012 10:16A M
-		Ŭ.	Prince George's Hospital Center	Cheverly		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign
	Director		163-22-9355 Usual Residence of Decedent		01/04/1	929 PA
	and show lat	or	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl 28a-f otifiec	Director	MD Prince George's Capitol	Heights		1 🏞 Yes 2 ☐ No
	h the	al D		Of. Zip Code	10g	. Citizen of What Country?
	tth wit ms 23 must	Funeral	613 Milwoof Drive	20743		USA
(0	or ite		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1950–1972 13. Was 1f Yes 1 □ Never Married 2 ☑ Married	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto	o Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	ırs aftı ırat", I Exar	Completed by		Yes 2 No Specify:		Specify: Black
5-0	"2 hou "natu	plet	(Specify only highest grade completed) (Give kind	's Usual Occupation of work done during most of wor	king 16	b. Kind of Business/Industry
12	ithin 7 ene. • than	Con	Elementary/Secondary (0-12) College (1-4 or 5+)	of Correctio	ns G	overnment
9	lled w I Hygi other ent, 1	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	
/lar	d be f Menta arked atic ev	임	Oscar Martin Harvey, Sr.	Julia	Thompson	
lan.	shoul and I	10		ddress (Street and Number or Ru		
e, N	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Helen Harvey/ Wife 613 Mi 20a. Method of Disposition 20b. Place of Disposition			ights, MD 20743
Baltimore,	age 1 int of it. If it		1 XBurial 2 Cremation 3 Removal from State cemetery, cremato	ry or other place)		c. Location - City or Town, State
Ė	partme portan injur			Natl.Cem 5/		nic Funeral Home
m	Depar Impor any ir	4	1 11/11/11/11/11/11/11/11/11/11/11/11/11	4 Old Washin		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician/	ř í	Immediate Cause (Final disease or condition as FATAL CARDIAC A	KRHYTHMIA		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		Jer	Sequentially list conditions, b. Dissite for as a nonsequence of:			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	ate be executed ohysician and the burial-transit	E E	resulting in death) Last Due to (or as a consequence of):			
09/	death certificate be executed he attending physician and ed for use as the burial-transi	edical	d			
687	ath certifica attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
Вох	leath o	icia	in the past 12 months? 1	ctopic pregnancy ther (specify)		Month Day Year
P.O.	es that the dea signed by the a I be detached f	Physician/Me	9 Unknown			<u> </u>
	The law requires that the atte has been signed by the page 2 should be detach		Part II. Other significant conditions contributing to death but not resulting in the unde PNEUWOTHOKAN	riying cause given in Part I.		co use contribute to the cause of death? 2 \(\sum \) No \(3 \sum \) Probably \(4 \sum \) Dinknown
ğ	requires been signatures	Completed by	PHEUMONIA		24a. Was an	24b. Were autopsy findings available
ec	e has age 2	omp	COD		autopsy performe 1 \(\superstack \text{Yes}\) 2	prior to completion of cause of
a F	ysician: The la s certificate ha director, page	Be C	25. Was case referred to medical	26. Place of Death (Che	,	SNo 1 ☐ Yes 2 ☐ No
₹	Physical this cerral direct	10	examiner? 1	Other: 4 Nursing H	lome 5 🗌 Residenc	e 6 Other (Specify)
٥	ling P. After ti	ate:	27. Manner of D th 1 Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how i	injury occurred
Sion	or Attending after death. Director: After tin by the fune	Certificate:	3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Stree	et and Number or Rural Route Number,
Division of Vital Records,	al or / s after il Dire		4 ☐ Homicide determined building, etc. (Specify)	,	City or Town, S	
_	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu (Check 2 Medical Examiner: On the basis of examination and/or investigat	urred at the time, date and place,	and due to the cause at the time, date and r	(s) and manner as stated.
	the lathin 2 the formulation	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, dea		place, and due to the c	ause(s) and manner as stated.
	F ≥ F 8		Knalol Bows M.D.	1 72 1 2	8 290	Date signed (Month, Day, Year)
-	000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print))) 0	101001
	P. KI		ROOZBEIL BADII, ND, 3001 HOSPITH	TO DRIVE CHE	VEXLY,	ND 30785
	Stat Registra		31. Date filed (Month ParyYear) 3 2012 32/fiegistrar's Signature.	Ked .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2012 Physician/ Apr 24 1:15 PM 4a. Facility Name (if not institution, give street and number) Hillegas Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Birthplace Country) PA **Funeral** 1 M 2 F Months Hours Min. (Month, Day, Ye Aug 10 Yrs. Director 93-18-0903 Usual F 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Cumberland MD 1 Yes 2 XNo Allegany 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? items 23a Funeral USA 21502 512 Winifred Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ Xio
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Xever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: "natural", Specify: 3 Divorced Completed white the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic execution. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Potomac Farms Dairy Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Imgrund Clarence Hillegas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26101 Parkersburg 608 Camden Avenue Grace Badgley sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/27/2012 St. John's Cemetery **New Baltimore** PA 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed and -trans that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop-performed 2 Nr Jas 2 🗌 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) **Division of Vital** Hospital 1 Yes 2 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certified April 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type-Print) Mos Calling 10600 Date filed 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Henry, Jr. Edward James 1850 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 203-26-7776 **Director** 1 🕅 M 2 🗆 F 78 07/18/1933 Pennsylvania Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director MD Allegany Cumberland 1 X Yes 2 □ No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1 Baltimore Street, Apt 417 21502 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc 0 þ 1 X Never Married 2 Married 2 No 1975-X Yes Yes, Give 3altimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🛣 No Specify "natural" Completed 3 Widowed 4 Divorced Specify. White 1977 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Journalist Newspaper traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o ပ္ Page 1 and 2 should be James Edward Henry, Jr. Naomi (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Slider / director assisted living of Health air 1 Baltimore Street, Cumberland, MD21502 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State = ò 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Cumberland Crematory 05/01/2012 4 ☐ Donation 5 ☐ Other (Specify) Cumberland. MD of Funeral Service Adams Family Funeral Home, 22. Name and Address of Facility ligi atur 404 Decatur Street, Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Metastalic 316 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (of as a consequence of) death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Chunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? 2X No ☐ Yes 2 N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) pletely filled in by the funeral director, Be Hospita Other: 1 Yes 2 Klo မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director. After tl 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year

MRS

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ardalan Enkeshafi. M.D., 12500 Wil

M.D.,

Registrar's Signature

Ardalan Enkeshafi,

2012

31. Date filed (Mogth,

*V1.1)

68 455

12500 Willowbrook Road, Cumberland, MD

30112

21502

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Gerald Higgins State of Maryland / Department of Health and Mental Hygiene 2012 15604 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day April 22, 2012 Medical Examiner 2104 hrs GERALD OLIVER HIGGINS 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6357 Neavitt Manor Road Neavitt 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 9. Birthplace (State or Months Days Hours Min Director Nov.29,1960 216-64-8116 1 X M 2 F 51 Country) MARYLAND Usual Residence of Decedent 10a State 10c. City Town or Location 10b County 10d. Inside City Limits MD TALBOT 1 X Yes 2 No NEAVITT Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6357 NEAVITT MANOR ROAD 21652 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White, etc. 2 Married Yes 4 X Divorced If Yes, Give Year 3 Widowed 1 Yes 2 X No specify: WHITE 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 3altimore, MD 21215-0036 12 PAINTER COMMERCIAL Com 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) 8 GEORGE HERMAN HIGGINS MARGARET JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE H. HIGGINS, JR., BROTHER 29468 CORBIN PARKWAY, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State NEAVITT CEMETERY 5/1/2012 NEAVITT, MARYLAND 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 SOUTH HARRISON STREET, EASTON, MD 21 JOHO R. MERCERO. 200 SOUTH HARRISON STREET, EASTON, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21601 **Physician** Approximate Interval Between Onset and /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed Physician/Medical s attending physician a for use as the burial - 1 UNPENDED AMENDED Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death Month Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the the The law requires that the 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hypercholesterolemia 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? page Yes 2 ✔ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 🗸 Natural 1 Yes 2 No Pending the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated g within 2 To the 1 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) tþ and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 23, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner HIVA RS Laron Locke MD. 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State 6 20 Registra

DHMH 17 Rev 1/2001 OCME 2006

12-03078 Matthew Heenan

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State of Maryland / Department of Health and Mental Hygiene

attije w Tieena		1- For State Certification 1 -	ficate of Death		20 l	2 1560
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) Matthew Patrick Heenan		2. Date of Deat Month April 20, 2	th	3. Time of Death 1215 hrs
eulcai Exam	mei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of E		4c. County of Death	12101110
		Suburban Hospital	Bethesda	la	Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 2 1 5 - 3 3 - 0 7 4 3 1 X M 2 F 2 0	birthday) If Under 1 Year If Under 2 Months Days Hours Yrs.	Min. 06/19	th(MM/DD/YYYY) 9. Birt /1991 Foreig Cor	
ow any			own or Location er Spring			10d. Inside City Limits 1 X Yes 2 No
e Maryland or 28a-f show	Director	10e. Street and Number 10007 Raynor Rd	10f. Zip Code 20901	10	ng. Citizen of What Cour	
ath with th	Funeral D	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P		- 14. Race - Ameri White, etc.	
ırs after de t ural", or i	by	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 No specify: 6a. Decedent's Usual Occupation (Give kin	nd of work done	White Specify:	
336 thin 72 hounder.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	during most of working life. DO NOT us Dispatcher		PG Towing	
Baltimore, MD 21215-0036 Depruit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of He land Mental Hygiewich Indopartment of Felands and Mental Hygiewich Indopartment of He and Mental Hygiewich Indopartment of them 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last) Kevin Patrick Heenan		Name (First, Middle, M ra Stearr	·	
MD 21 d 2 should lth and Me n 27 is ma	To	19a. Informant's Name/Relationship (Type, Print) Kevin Heenan/ Father	19b. Mailing Address (Street and Number 10007 Raynor Rd)			
ore, Mes 1 and 2 of Health If item 2		20a. Method of Disposition 20b. Plac	4 PC - 32 - 44 - 4 - 1	Date	20c. Location - City or 2 Riverda	Town, State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Chilly Sell 8 4 000 30	22. Name and Address of Facility Murray Funeral	Home Wa	35 Eads S	L,NE
Physician	- 1	23a. Part I. Enter the disease, or complications that caused the death. Do				Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of):	of Head			Between Onset and Death
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	Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
cuted and transit	al Exa	events resulting in death) Last Due to (or as a consequence of): d.				
60, ate be exe hysician a	edica	UNPENDED AMENDED				
Box 68760, death certificate be executed the attending physician and dfor use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopic pr	regnancy	23d. Date of delivery Month D	ay Year
Box e death the atter	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
P.O. res that th signed by be detach	ě	Part II. Other significant conditions contributing to death but not result	Ilting in the underlying cause given in Part I		bacco use contribute to t 2 No 3 Prob	
in of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and limeral director, page 2 should be detached for use as the burial - transit	Completed			24a. Was a autop: perfor	sy prior to co med? death?	opsy findings available ompletion of cause of
al Re	Be Co	25. Was case referred to medical	26.Place of Death (Ch	1 ✓ Yes 2 neck only one)	2 No 1 ✓ Ye	2 No
Vit;	F B	Tes 2 No		lursing Home 5		
		1 Natural 5 Pending Apr 18, 2012 Pending O(Bb. Time of Injury 28c, Injury at Work? 038 hrs 1 Yes 2 ✓ No	Subject shot	ow injury occurred self	
Division ttal or Attendii urs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Gas station	e, farm, street, factory, office building, etc.	or Town, St	treet and Number or Rur late) Avenue, Silver Spring	
Division of V To the Hospital or Attending Ph within 24 hours after designed. To the Funeral Director: After t completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or				
To with To con	Æ	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
(A)		Earol Hallan	O.C.M.E.		April 25, 2012	
1		Name and address of person who completed cause of death (Item 23: Carol Allan, MD		e, MD 21223		
St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	K)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Conrad Howard Haffmans 7:35 AM April 29 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 217-82-4261 Director 1 X M 2 D F 60 May 9, 1951 New Jersey Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ns 23a c must b Funeral 20715 4000 Clover Court USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☒ No If Yes, Give 0 ģ 1 X Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked the Never Worked h and Mental Hygier 7 is marked other t Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked or မ Henry John Haffmans Felicia Vincent traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 Berwyn Road, Berwyn Heights, MD 20740 Antonia L. Brown / Case Manager it of Healt If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 🗌 Burial 2 🖾 Cremation 3 🗌 Removal from State Department of Important: If any injury or 5/10/2012 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Years shock, or heart failure. List only one cause on each line Immediate Cause (Final Ptwwician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been similar to the certificate to the certificate has been similar. burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death 2 X No 9 Unknown 9 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 Yes 2 No 3 Probably 4 X Unknown Developmental Delay Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 X No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗵 No Other: 1 Inpatient 2 SER/Outpatient 3 DOA 은 4 Nursing Home 5 Residence 6 Other (Specify, 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending ours after death.

leral Director: Af
filled in by the fu 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) e and title of certifier Sign 29c. License number 29d. Date signed (Month, Day, Year, D43539 4/29/2012 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Raymond Magnus White, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910 Date filed (Month, Day, Ye Registra 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2:37 P M 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANGELO **JACKSON** APRIL 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CIVISTA MEDICAL CENTER LA PLATA CHARLES Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) NORTH **Funeral** JUNE 13 723-03-9708 **Director X**M 2 □ F 80 Yrs CAROLINA Usual Residence of Decedent 1931 show or 28a-f shov notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES WALDORF 1 Tes 2XXVo 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumati-3605 MOSES WAY #106 20602 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forc Black, White, etc 2 1 Never Married 2 X Married Yes 2XXNo Specify: BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 🌠 Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) US STEEL LABORER (US STEEL WORKER) 8TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROSCELL **JACKSON** CARRIE OWENS JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8534 SPUR COURT, WALDORF, MICHAEL A. JACKSON SON MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MAY 05, RIVERDATE" PARK CREMATORY 1 Burial XXCremation 3 Removal from State RIVERDALE, MD 4 Donation 5 Other (Specify) 2012 gnatur of Funeral Service Licensele
TERRENCE L. J JOHNSON#M00993 4433 WHITE PLAINS LANE, WHITE PLAINS, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death the Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4XXInknown Completed been s 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 X X death? Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2XXIo 1 ☐ Inpatient 2 🛛 🛣 Outpatient 3 ☐ DOA မြ 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C Medical 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nurse Freetitioner 29b. Signature a d title of certifier

State Registrar 31. Date filed (Month

29d.

signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month LaRue B. John 28 April 6:30 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>153</u> Harwood Road Harwood Anne Arundel If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min Mary Land 89 219-16-<u>1069</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Harwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 153 Harwood Road 20776 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Worker <u>Postal Service</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence D. Kolb <u>LaRue Wayson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician/ Medical Examiner

inding physician and use as the burial-trans

attending physician for use as the burial

signed by the all to be detached for

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Funeral Director: After this releted filled in by the funeral dil

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Completed

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Certificate:

Medical

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2 TNo

the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic

Physician/

Medical

10a. State

Director

Funeral

Completed by

Be

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Examiner

Funeral

Director

th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of Injury that initiated events resulting in death) Last Examiner Physician/Medical

Immediate Cause (Final disease or condition

resulting in death)

20a. Method of Disposition

Sharon Waldow/Daughter

of Fw I Service Licensee

4 ☐ Donation 5 ☐ Other (Specify)

1 Durial 2 X Cremation 3 Removal from State

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dementia Due to (or as a consequence of):

153 Harwood Road.

20b. Place of Disposition (Name of

Kalas

cemetery, crematory or other place,

2973 Solomons Island Rd., Edgewater

Interval Between Onset and Death vears

Year

Were autopsy findings available prior to completion of cause of death?

2012

1 ☐ Yes 2 ☐ No

Due to (or as a consequence of) Due to (or as a consequence of):

Harwood, MD

22. Name and Address of Facility George P. Kalas Funeral Home

20776

04/30/2012 Edgewater, MD 21037

20c. Location - City or Town, State

FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🔀 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)	_
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part	

egnancy cify)

23e. Did tobacco use contribute to the cause of death? 2 🕅 No 3 🗆 Probably 4 🗆 Unknown

23d. Date of delivery

Month

1 🗆 Yes
24a. Was an autopsy performed?

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred

27. Manner of Death X Natural 5 Pending Investigation
6 Could not be 1 Tes 2 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

D40210

29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cortifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Leslie F. Brooks. MD134 Owensville Rd, West River, MD 20778

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month $20\overset{\mathrm{Yea}}{12}$ Teresa Trapani Johnson 4:45 P M April Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day Director 84 Washington, D.C 579-38-7032 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Montgomery Derwood MD 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 18612 Muncaster Road 20855 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Deceue... Armed Forces? ⁴ ☐ Yes 2 🔀 No 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify. 3 🛚 Widowed 4 🗌 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 0 traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fish marked or ပ Department of Health and Menta Important: If item 27 is marked any injury or other to any i DiMisa Salvatore Trapani Caterina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Fantacci/Daughter 18221 Mulberry Court, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 5/2/2012 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 22. Name and Address of Facility Muriel H. Barber Funeral Home 21, Signature of Funeral Service Licenses Ro P.O. Box 5038, Laytonsville, Maryland 20882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dea h Immediate Cause (Final Physician 6 Carvcer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Unknown been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed after death.

Director: After this certificate | 2 100 Yes To Be 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) examiner' Hospital Other: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending injury work? 1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Uhn

31. Date filed (Month, Day, Year)

91

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State of	Maryland / Depa			tal Hygien		15610		
_			Registrar 1. Decedent's Name (First, Middle, Last)	Cen	tificate of Death		Reg. No	10. 2012	10010		
	Physicia Medic		JAMES C. JONES				PRIL 18,	2012 Year	3. Time of Death 11:25 P M		
	Examin		4a. Facility Name (if not institution, give street and numb DORCHESTER GENERAL HOSP)	·	4b. City, Town, or Location CAMBRIDGE	n of Death		lc. County of Death	ER		
	Funeral Director		213-60-9099 1X M 2 □ F	'. Age (In yrs. last birthday) 60 _{Yrs.}	If Under 1 Year If Under Months Days Hours	Min. (/	Date of Birth Month, Day, Year	lay, Year) Country)			
	and show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		•		10d. Inside City Limits		
	e Maryl r 28a-f notifie	Director	MD CAROLINE	PRESTO					1 🔀 Yes 2 □ No		
	with the 23a or 1st be	Funeral L	10e. Street and Number 116 WILLIAMSON STREET		10f. Zip Code 21655			10g. Citizen of What Country? USA			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Deced Armed Forc 1 □ Yes 1f Yes, Give Year or Dat	es? If 2 🗓 No 1	las Decedent of Hispanic Ol Yes, specify Cuban, Mexica Yes 2 X No Specify	an, Puerto Ricar		14. Race - Ameri Black, White, Specify: WH			
21215-0036	2 hours "natur edical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation ind of work done during mo	ost of working	16b.	Kind of Business/Ir			
2121	within 7 giene. er than the Me		Elementary/Secondary (0-12) College (1-4	or 5+) Iife. DC MECH	NOT use retired) ANIC		ΑŪ	JTOMOBILE			
Maryland	2 should be filed with h and Mental Hygien 7 is marked other t traumatic event, the	To Be	17. Father's Name (First, Middle, Last) GEORGE A. JONES, SR.			ther's Name <i>(Fir</i> s	st, Middle, Maide THOMAS	n Surname)			
	nd 2 shoul saith and I n 27 is ma	3	19a. Informant's Name/Relationship (Type, Print) LESLIE E. THOM, DAUGHTER	1	g Address (Street and Numb TALBOT AVENU				Code)		
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)		ition (Name of atory or other place) H CEMETERY	Date 4/25/2		Location - City or T			
Balt	permit. Departr Import. any inji		21. Signal for of Fundral/Service	CFSP FE	Name and Address of Facil LLOWS, HELFE O SOUTH HARR	NBEIN & ISON ST	NEWNAM REET, EA	FUNERAL ASTON, MA	HOME, P.A. RYLAND21601		
	Thysician/		23a. Part 1. Enter the disease, or complications had ca shock, or heart failure. List only one cause or wead Immediate Cause (Final disease or condition	used the death. Do not enter h line.	the mode of dying, such as	s cardiac or resp	piratory arrest,		Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death) a. Due to (o	ras a consequence of):	12 Malis	nones					
	ited J ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):	0						
0	death certificate be executed ne attending physician and ned for use as the burial-transit	dical Ex	that initiated events resulting in death) Last C. Due to (o	r as a consequence of):							
8760	tificate ing phy e as the	Med	IF FEMALE:	7.4							
. Box 687	ne death certifica y the attending ph iched for use as t	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	very Day Year		
ls, P.O.	uires that the dea n signed by the a uld be detached t	ed by P	Part II. Other significant conditions contributing to dea	ath but not resulting in the ur	derlying cause given in Par	rt I.		o use contribute to t	he cause of death?		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. Of the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed by					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of		
<u>a</u>	sian: T ertifical ector, p	Be C	25. Was case referred to medical examiner?		26. Place of De	eath (Check only	1 L Yes 2 L one)	No I L res	2 L J NO		
Ž	ding Physician. The law h. Affer this certificate has funeral director, page 2	၉	1 Yes 2 No Hospital: 1 In 127. Manner Death 28a. Date o	npatient 2 ER/Outpatient	3 DOA Other: 4 N		5 Residence Describe how inju	6 Other (Specif	y)		
ouo	ending sath. or: After the fune	Certificate:	1 ☐ Natural 5 ☐ Pending (Month 2 ☐ AccidentInvestigation	, Day, Year) injury	work? M 1 Yes 2		Describe flow mj	ary boodings			
Divisi	tal or Attendi rs after death al Director: A led in by the f			f Injury - At home, farm, stre g, etc. <i>(Specify)</i>	et, factory, office		ocation (Street a Dity or Town, Sta	und Number or Rura te)	l Route Number,		
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis only one) 3 Certifying Nurse Practitioner:	of examination and/or investi-	gation, in my opinion, death of	occurred at the ti	ime, date and pla	ce, and due to the ca	ause(s) and manner stated.		
	To the Withir To the сопр	2	29b. Signature and title of certifier	DH MD	29c. License number		29d. D	Date signed (Month,	Day, Year)		
			30. Name and address of person who completed cause	of death (Item 23a) (Type, Pr	D 47			1,24	112		
R	.5 6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOMAN THANNY 503 BYRN ST CAMPRIDGE MD "4613"								
	Stat Registra	e ir	31. Date filed (Month, Par Year) 6 2012 32. Re	istrar's Signature	and						

DHMH 17 Rev 06-2011

12-03276 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Glendora Marie Jones State of Maryland / Department of Health and Mental Hygiene 2012 1561 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 27, 2012 Mędical Examiner 1317 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death Cambridge 503 Muir Street #208 Dorchester If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Hours Director -9266 2**X** F 1___ M Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h Count 1 X Yes 2 No MD ambri permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygöre.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho in lail or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21613 Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X No Yes Black 3 X Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Production Worker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname Jackson Be Saia Vora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Church Rd-Seaforo daughter 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cambridge, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licen 22. Name and Address of Facility Bennie Smith Funeral Home aston. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Exsanguination Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Ulceration of Dialysis Shunt Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and led for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED Box 68760, IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Ectopic pregnancy Day past 12 months? Pregnant at time of death 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should be 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 V No 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this 2 1 🗸 Yes 27. Manner of Death 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred uncontrolled bleeding from ulcerated dialysis FOUND: Division Natural 1 Yes 2 ✔ No 5 Pending within 24 hours after death.

To the Funeral Director: the Apr 27, 2012 1303 hrs 2 🗸 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e: Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 503 Muir Street #208, Cambridge, MD determined (Specify) Multi-Family Apt. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E April 28, 2012 125 30. Name and eddress of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Melissa Brassell, MD

ORIGINAL

900 W. Baltimore Street, Baltimore, MD 21223

Assistant Medical Examiner

32 Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joseph Paul Ko		1- For State Registrar	State of Maryla		tificate of		iu ivieri	пат нус		eg. No.	20	12	1561
Physic Medical Exam		Decedent's Name (First, Mid Joseph Paul k							Date of Deat Month May 5, 20	Day	Year		of Death 4 hrs
		4a. Facilify Name (if not institut	ion, give street and nur	mber)	4	o. City, Town, o	r Location o		Way 5, 20	4c. Co	unty of De		
مر Funeral		999 West Patrick Str 5. Social Security Number		7. Age (In yrs. Ia	st birthday)	Frederick If Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Birt		erick	Birthplace (S	state or
Director		220-02-9245	1XM 2F	29	Yrs.	Months Da	ys Hours	Min	04/28/		For	eign	laryland
any		Usual Residence of Decedent 10a. State 10b. County	/	10c. City,	Town or Location	n						10d. Ins	ide City Limits
Maryland 28a-f show d at once.	草		lerick	Fre	derick								es 2 X No
he Mary or 28s	Direc	10e. Street and Number	1 D 1			10f. Zip Code			10	og. Citizen o		-	
h with t ms 23a be not	Funeral Director	8111 Clearfiel 11. Marital Status	12. Was Dece	edent Ever in U.S		21702 Decedent of Hi	spanic Orig	jin? (Speci	ify Yes or No-				
ter death , or ite] [Married Armed For 1 Yes	2 X No		s, specify Cuba Yes 2 🏋 No							
iours afi Latural'	ed by	15. Decedent's Education (Spo	ecify only highest grade		16a. Decedent		tion (Give I	kind of worl		16b. Kind		hite s/Industry	
36 Jiin 72 h e. ihan "n rdical E	Con:pleted	Elementary/Secondary (0-12)) College (1-	4 or 5+)	_	ssemble		use retired)	N	Manuf	actur	ino
MD 21215-0036 11.2 should be filed within 7 12 and Mental Hygiene, 12.7 is marked other ihan umatic event, the Medica		17. Father's Name (First, Middle					18.Mother's Name (First, Middle, Maiden S Nancy Ruzga				Manufacturing Surname)		6
212' 212' ould be Mental marke	Robert Kozloski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Add					Address (Stre		-	_	ber, City or	Town, Sta	ate. Zip Code	9)
, MD and 2 sho salth and raumat	Robert Kozloski / Father 8111 Cle						1d Ro	ad, F	rederi	ick, M	Mary1	and 21	L702
Maryland Frederick 10e. Street and Number						r place)			ate) / 2 () 1 2			or Town, Sta	
laltin rmit. P epartme nportan		4 Donation 5 Other S 21. Signature of Funeral Service										-6, 110	
M014/3 106 East Church Street, Frederic 23a (Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory arrest, sh							ck.		701 imate Interval				
/Medical Examiner	Medical failure. List only one cause on each line.								Betwee	on Onset and Death			
		or condition resulting in death)	Due to (or as a c	consequence of):									
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ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	_								
68760, certificate be executed nding physician and se as the burial - transit	Medical	X UNPENDED	d2.	3a,27,28	Ba−t,per	me,g9	27 5-	18–12	sm				
3760, ficate be g physici s the bun		IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes, ou	tcome of pregna							23d. Date of delivery		
	Physician/N	past 12 months? 1 Yes 2 No 9 Uni	4 Pregnar	nt at time of deat	, - H	Fetal death 3 Ectopic pregnancy Other (Specify)					Month Day Year		Year
m 5 4 8		Part II. Other significant condit	9 Unknow		ulting in the und	lerlying cause (given in Par	t I.	23e. Did tob	acco use co	ontribute t	o the cause	of death?
ords, P.O. w requires that the seen signed by should be detact	ed hy								1 Yes	2 🗸 No	3 Pr	obably 4	Unknown
Cord law req has bee	Completed								24a. Was ar autopsy perform	У		completion	ngs available of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medica	1			26.Place	of Death (Check only	1 Y Yes 2		1 🗸		2 No
	To Be	examiner? 1 Yes 2 No			R/Outpatient :			Nursing Ho		esidence		er: Scene	
_ # . ₹ d	1.27 Manner of Death 128a Date of Injury 1.29b Time of Injury 1.20c is								Describe ho		-	oxycod	one
Division pital or Attendi ours after death. reral Director: /	ertification:	3 Suicide 6 Coul	d not be	of Injury - At hom	e, farm, street,	actory, office b	uilding, etc.	. 28f.	Location (Str	reet and Nu	mber or R	ural Route N	lumber City
10 B 10 10 10 10 10 10 10 10 10 10 10 10 10	OF	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 999 West Frederick, MD. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as st											
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated.								he cause(s)			
	29b. Signature and title of certifier 29c. License number 29d. Date signed (M. O.C.M.E. May 6, 2012							onth, Day, Ye	ar)				
	}	30. Name and address of person		•	•					-			
	ate	Donna M. Vincenti, MI				. Baltimore	Street, E	Baltimore	e, MD 212	23			
Regist	rar	31. Date filed (Mogth Day Year) 32. Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		lental Hygie					
			3	ertificate of Death	Reg.	.No. 2012 5613				
	Physicia		1. Decedent's Name (First, Middle, Last) Norma Pucci Lebling		2. Date of Death Month April 24	Day Year 3. Time of Death 8:00 P M				
<u> </u>	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	APITE 24	4c. County of Death				
Same.	<i>!</i>		Spa Creek Center	Annapolis		Anne Arundel				
\$\begin{align*} & \text{\$\pi\$} & \te	Funeral Director		5. Social Security Number 069-14-0856 Usual Residence of Decedent 6. Sex 1 □ M 2 M F 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 3/9/192)	9. Birthplace (State or Foreign Country) New York				
	and show dat	tor	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits				
	Maryl 28a-f otifie	irec	Maryland Anne Arundel Harwoo	od		1 🗆 Yes 2 🗓 No				
	rith the 23a or st be r	Funeral Director	10e. Street and Number 4908 Sudleys Choice Lane	10f. Zip Code 20776	10g.	. Citizen of What Country? USA				
	eath w	Fune	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	14. Race - American Indian,				
036	and 2 should be filed within 72 hours after death with the Manyland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 1 Never 1 No. 1	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: White				
2-0	2 hour "natu	plet	15. Decedent's Education 16a. Dece	edent's Usual Occupation kind of work done during most of working	na 16k	p. Kind of Business/Industry				
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ylar	should be filed what and Mental Hyg 7 is marked other traumatic event,	10	Orturo Pucci	Eli	sa Vaccar	i				
Maryland 21215-0036	2 shouth and 1th and 27 is not traum			ing Address (Street and Number or Rura Sudleys Choice La:						
Baltimore,	of Heal of Heal fitem		20a. Method of Disposition 20b. Place of Dispo	osition (Name of		c. Location - City or Town, State				
E	Page 1 ment of I tant: If it		4 □ Donation 5 □ Other (Specify) Kalas C	rematory or other place) rematory 4/26		dgewater, MD				
Balt	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr				las Funeral Home gewater, MD 21037					
			23a. Part 1. Enter the disease, or complications to t caused the death. Do not ent shock, or heart failure. List only one cause on thich line.	er the mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between				
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medi.	Examiner	٦.	Sequentially list conditions, b. Hual F. Sequentially list conditions,	illation		Gear				
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20 X 08	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
л. Э.	ed by detac	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?				
ds, I	quires t			•	1 🗆 Yes	2 No 3 Probably 4 Unknown				
Records,	he law rec te has ber age 2 sho	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?				
Vital	sian: T		25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2 2 only one)	No 1 Yes 2 No				
<u> </u>	Physic this ce	၉	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			6 ☐ Other (Specify)				
n or	nding I th. : After e funer	cate	27. Manner of Death 28a. Date of injury 28b. Time of injury	f 28c. Injury at 2 work? M 1 ☐ Yes 2 ☐ No	8d. Describe how in	jury occurred				
DIVISION	or Atter after dea Director	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stribuliding, etc. (Specify)		28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)				
ב	Hospital 24 hours Funeral stely fillec	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								
		Hy J. Vaus MD D53111 4/26/2012								
7	H3+1		30. Name and address of person who completed cause of death (Item 23a) (Type, F Hung T. Davis, M.D. 2007 Tidewater	Colony, 1-A, Anna	polis, MD	21401				
	Stat Registra	~	31. Date filed (Month, Day, Year) 32. Registrar's Signature	bare						
				P						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per verb 9928 6-26-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day 12 oore Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner MARYLA linton YrInce 1 Year If Under 24 Hrs. 9. Birthpla 7. Age (In vrs. last birthday 8. Date of Birth (State or Foreign **Funeral** Hours Min (Month, Day, 219-48-6416 **Director** 1 🗆 M 2 🕱 F 64 MARYLAND Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits ian "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 1 X Yes 2 □ No beurge ARYLAND Ivvine 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 7604 USA 20613 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of the state of th Federal life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Governmen Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, ပ္ Moore Sr White Dudner lornease Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Inf rmant's N-me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CH Wheeler 2402 Collas Kesia 20603 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗔 Removal from State etery, crematory or other MI m Brandywine 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee Name and Address of Facility MI) 20608 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** certensi if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to To the Hospital or Attending Physician: The law requires that the death certificate be executed perlipid and burial-tra Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 month Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has page 2 autopsy performed' 2 🗌 No 1 🗌 Yes Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Other: 2 🗖 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 \(\text{Yes} injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D 62057 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Month

Day

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3 2012

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 7: 45 PM Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MOORE Month 4 Zol2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL UNION ELKTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country TEXAS 1 🔀 M 2 🗆 F Months Hours 725 09 4476 86 **Director** show 10b. County
PRINCE 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 4YATTSVILLE 1 X Yes 2 No GEORGE'S 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral U5A 20 NWOOD TREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) VERNMENT WORKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ MYRTLE LOHNSON permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BAYCLUB PARKWAY DAMIRA JUNES 116 Baltimore, 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place)

HARYLAND NATIONAL U.5 OI ZUIZ LAUREL MAN

22. Name and Address of Facility CHINN-BAKER FUNTAL 1X Burial 2 Cremation 3 Removal from State LAUREL MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 2605 S. SHIRLINGTON ROAD ARGINGTON VA 22206 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) ears Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate F Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Ba Hospital Other: 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ■ Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after deat

To the Funeral Director,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titles certifier 0

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

NAY 0 2 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S 874-CHDEV MD, 126 A,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Montl Pearl R. Marble 26. A^{M} April 6:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Center Takoma Park Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Hours **Director** 080-22-9724 1 □ M 2 🗓 F 92 1919 6, South Carolina 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 33-47th Street SE 20019 United States items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Examiner Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 be filed within 72 hours after Specify: African If Yes, Give 1 Yes 2 No Specify "natural", Completed 3 Nidowed 4 Divorced Year or Dates Ámerican other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Practical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H marked o ည unk. unk. 1 and 2 should b f Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20785 203 Royal Oak Circle Landover, Maryland Sandra Peay - Daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Page 1 cemetery, crematory or other place, May 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 2012 Brentwood, Maryland Signature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewar M00560 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Acute Cardio Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chromic Kidney Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin burial-transi Cause (Disease or injury that initiated events Chromic Hypertensive Heart Disease and Due to (or as a consequence of). resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ō Day Pregnant at time of death the 9 Unknown Unknown signed by the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>수</u> Completed 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed r certificate ! 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 XNO ျှ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident death. within 24 hours after death

To the Funeral Director: /
completely filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medica 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number May 1, 2012 D0063232

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

20850

Rockville, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Gomez MD 15245 Shady Grove Road

12-03222 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Steven Northcraft State of Maryland / Department of Health and Mental Hygiene 2012 1561 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 25, 2012 **Medical Examiner** Northcraft 0955 hrs Lee Stephen 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 911 Michigan Avenue Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** Days Foreign Maryland Months Hours Director 219-46-1660 1 X M 2 F 09/07/1955 56 Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Cumberland Allegany 1 X Yes 2 No MD or 28a-f show ii. Pages I and 2 should be filed within 72 hours after death with the Maryland riment of Health and Mental Hygiene.
or other (Frank 27 is marked other than "..." If item 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, <u>the Medical Examiner m</u>ust be notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21502 911 Michigan Avenue Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? Never Married 2 Married White, etc. If Yes, Give Yaar or Dates: 4 X Divorced 1 Yes 2 Y No specify: Specify: Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) State of Maryland Director of Youth Center 18.Mother's Name (First, Middle, Charlotte 17, Father's Name (First, Middle, Last) Maiden Surname) Elizabeth Vernon Northcraft Gano Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Quaker Ridge Road, Timonium, Donald F. White, III / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State rematory or other place)
Vet Cem @ Rocky Gap 1 X Burial 2 Cremation 3 Removal from State MD 04/30/2012 Flintstone, MD Donation 5 Other Specify Adams Family Funeral Home, P.A. 22. Name and Address of Facility 1. Signature of Fufteral Service License 21502 404 Decatur Street, Cumberland, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** fatiure. List only one cause on each line Between Onset and /Medical a. Contact Gunshot Wound of Chest Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit of Vital Records, P.O. Box 68760, ng Physician: The law requires that the death certificate be executed Sal signed by the attending physician a be detached for use as the burial -UNPENDED AMENDED Physician/Media IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the Live birth Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? certificate Yes 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. director, 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA this 1 V Yes မှ the funeral 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification ___ Natural Subject shot self FOUND: Division 1 Yes 2 ✔ No Pending the Funeral Director: Apr 25, 2012 0940 hrs 2 ___ Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 🗹 Suicide Could not be 911 Michigan Avenue, Cumberland, MD determined (Specify) residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 26, 2012 0 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Months Dev.) 1949 1 32. Registrar's Signature State CARCO a seeme Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 BERTIE EDNA NINER ñ2 2012 5:30 P.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Assisted Living Frostburg Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 98 Hours (Month, Day, Yea 09/22/191 Country) Marvland Director 220-28-7547 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Allegany Cresaptown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Niner's Lane 21502 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 ☐ Yes 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White 3X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Factory Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Peter Martin Martz Ellen L.Cadwalder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12518 McMullen HIghway, S.W., Cumberland, MD 21502 Patricia Scott / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) X Burial 2 Cremation 3 Removal from State St. Ambrose Cemetery | 05/08/2012 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown, MD Signature of Funeral Service Lice 22. Name and Address of Facility Upchurch Funeral Home, P.A. 202 Greene Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 24/E/m/E/2 Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy sate has been signed by the atterpage 2 should be detached for it in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🞾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2. autopsy performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Other: 1 🔲 Yes 2 **P** No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 026907 HIrden

Registrar

DHMH 17 Rev 7/2009

State

- 925 Bishop Walsh Road, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Harjit Sidhu, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL ANNIE ጟሽ 2012 OLDEN 1610 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 578-22-6906 95 Director 1 M 2 X F APRIL 26,1917 SC 28a-f shov 10d. Inside City Limits at 10a. State 10b. County 10c. City, Town or Location Director must be notified 1 X Yes 2 No DC WASHINGTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral with 1229 G STREET SE, #225 20003 items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify. BLACK Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) 9TH Hygiene. College (1-4 or 5+) the PRIVATE HOUSEKEEPING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ? ပ္ MARIA OLIFFANT TOM BUTLER permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD OLDEN/SON 204 COSKY DRIVE #220, MARINA,CA 93933 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State ARLINGTON, VA 5-10-12 injury o 4 Donation 5 Other (Specify) INGTON CEMETERY Signature of Funeral Service Mice 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. any 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner n4es Gre Sequentially list conditions Examine cause. Enter Underlying Due to for as a conscolungs of that the death certificate be executed as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပု 1 Hinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred s after dec. al Director: Afte 1 ₩ Natural 5 Pending 1 Tes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00060100 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD Ent y Unevent Silve 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Price Viola Elizabeth Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 04/01/1931 Maryland 217-28-0351 **Director** 1 🗆 M 2 💢 F 81 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City. Town or Location 10a State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho at **Funeral Director** must be notified 1 Yes 2 No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 2**1**502 10e. Street and Number 16111 Collier Run Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Florist Bookkeeper / Designer 18. Mother's Name (First, Middle, Maiden Surname)
Orgle Peachie L. Be 17. Father's Name (First, Middle, Last) Lambert Olie Johnson Walter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 294 E. Main Street, Frostburg, MD 21532 19a. Informant's Name/Relationship (Type, Print) Penny L. Price / Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 0 1 X Burial 2 Cremation 3 Removal from State Price Cemetery Little Orleans, MD 05/08/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. of Funeral Servi Licensee 21502 404 Decatur Street, Cumberland, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Heart failure. List only one cause on each line. CEREBROUASCULAR ACCIDENT Onset and Death BRAINSTEM Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence oil. physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury at work? 1 🗆 Yes 2 🗆 No injury 1 Natural 5 Pending Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific MAY6,2012 on who completed cause of death (Hem 23a) (Type, Print)
n, M.D., 12502 Willowbrook Road, Cumberland, MD 21502 Qamar Zaman, M.D., MX 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Physician/ P M 12:35 Oscar L. Preston 2012 04Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Frostburg Nursing & Rehab. Center Frostburg Allegany Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Months Hours Min January 14, 1933 Maryland **Director** 215-26-9720 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location aţ Director notified 1 ☐ Yes 2 🗶 No Allegany Mount Savage Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 15928 Mount Savage Road, N.W. Examiner must be 23a Funeral U.S.A. 21532items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ò þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. KOREAN 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Textile Manufacturing 0 Tin Shop Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ Anna Ethel Murphy Clarence W. Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21545-Maryland P.O Box 516 Mount Savage **Betty Preston** wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Mount Savage Maryland Saint George's Cemetery May 07, 2012 21. Signature of Funeral Service Lice 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 blin 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclero HC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) burialattending physician for use as the burial Physician/Medical that the death certificate be Box 68760 the SS IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has certificate Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 1 Yes 2 XVo 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 29a. Certifier LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотрыете 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, worrock 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walsh MID 21502 Rd Bishox SHIN State 32. Registrar's Signati

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SYLVESTER ROBY PARSONS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Western MD Regional Medical Center If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 09/19/1938 235-62-1885 **Director** 1 X M 2 D F West Virginia Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 🗆 Yes 2 🖁 No Fort Ashby Mineral 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 r must be r Funeral 26719 Route 2, Box 259 permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. the Natural 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status ed Forces? Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give
Year or Dates. 160-166 1 ☐ Yes 2X No Specify. Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Stee1 Floorman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maxine Margaret Williams Sylvester Harmon Parsons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon Borror / Sister 1101 E. First Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bethel Cemetery 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 04/28/2012 Parsons, WV 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service (lice) ee 22. Name and Address of Facility Upchurch Funeral Home, 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ptaymiciany Probable disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alcoholi sm 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? tobacco Abuse 24a. Was an , page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 X No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) ted cause of death (Item 23a) (Type, Print) Ceemberland, Willowbrook Road.

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Conrad Prinn 2:01 May 2012 \mathbf{a}^{V} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year) **Director** 216-20-1939 1 **X** M 2 □ F 86 10/18/1925 MD show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 K No Ellicott City MD Howard 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 2629 Orchard Avenue 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CSX Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Conrad Prinn Marion Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2629 Orchard Avenue Ellicott City, MD 21043 1 and 2 s f Health a item 27 i Virginia Bowen Prinn - Wife injury or other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott № Burial 2 Cremation 3 Removal from State Garrison Forest Vet. | 05/09/2012 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 ollmo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death WEEK Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Examiner month Dysphasgia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): years Dementia Alzheimer Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 🗌 Yes 2 🗀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 **X**No 4 Nursing Home 5 Residence Other (Specify) Hospice 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending I 24 hours after death. X Natural work? injury 5 Pending e Funeral Director: Af letely filled in by the fu 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) May 2, 2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Columbia, MD 6336 Cedar Lane 21044 Bindu Joseph, MD

DHMH 17 Rev 06-2011

State Registrar egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Of Its		artment of Healtr tificate of Death		Reg.	401	2 1562
	Physicis		Decedent's Name (First, Middle, Last)			2.	Date of Death		3. Time of Death
	Physicia Medic	al	Lillian Bell Roy		The City Town and a series		pril :	27, 2012 4c. County of Death	6:20 A M
	Examin	er	4a. Facility Name (if not institution, give street and number Prince Georges Hospital C		4b. City, Town, or Locatic	on of Death		Prince Ge	- 1
	Funeral			age (In yrs. last birthday)			Date of Birth (Month, Day, Yea	g. Birtl	nplace (State or Foreign intry)
	Director		214-18-8579 1 ☐ M 2 🗓 F Usual Residence of Decedent	90 Yrs.	Working Days Tribate		2/08/19		VA
	and show Lat	or	10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	Maryli 28a-f otifiec	Director	MD Prince Georges	Bowie					1 ☐ Yes 2X No
	th the 3a or t be n	ral D	10c. Street and Number		10f. Zip Code 20721		10g	, Citizen of What Co USA	untry?
	ems 2	Funeral	10450 Lottsford Road 11. Marital Status 12. Was Deceder		Was Decedent of Hispanic	Origin? (Specify	Yes or No-	14. Race - Amer	
98	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give	· No	f Yes, specify Cuban, Mexi □ Yes 2 🙀 No Spec		an, etc.)	Black, White	
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ary	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Nur	mber or Rural R	oute Number, Cit	ty or Town, State, Zip	Code)
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from Sta		psition (Name of matory or other place) Mem. Gardn.	May 12		c. Location - City or	
Ħ.	mit. Pa bartme bortan injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		Name and Address of Fa				7
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			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not enter line.	er the mode of dying, such	as cardiaç or re	espiratory arrest,		Approximate Interval Between Onset and Death
وأوالعم	Medical		Immediate Cause (Final disease or condition resulting in death)	AL (47()) as a consequence of):	uc ARRI	49mm	A		
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E B	ysician: The la is certificate ha director, page	ره ا	25. Was case referred to medical		26. Place of I	Death (Check or	1 ☐ Yes 2 l nly one)	VNol 1 □ Yes	3 2 No
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Division of Vital Records,	tten dea stor: y the	Certificate:		Injury - At home, farm, str			f. Location (Street	et and Number or Ru	ral Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the besis (Check only one) 3 Certifying Nurse Practitioner: To	of examination and/or inves	stigation, in my opinion, deat	th occurred at th	e time, date and i	place, and due to the	cause(s) and manner stated.
	To the within To the compl	Σ	only one) 3 L Certifying Nurse Practitioner: To 29b. Signature and title of seatifier	the post of my knowledge	29c. License numb			d. Date signed (Mont	
			1 Smfm 7 S	po	1/2 60	7688		April 3	0,2012
(THAD		30. Name and address of person who completed cause of	of death (Item 23a) (Type,	Print) De M	LIVIR	10 0	nn 21.	785
	Sta	te	31. Date filed (Month, Day, Year) 32. P/g	strar's Signature	1	IL VEI	7		
	Registr	ar	MAY 0 1 2012	ma a. A	ace				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #18, nls, per FD, 05/04/12, State of Maryland / Department of Health and Mental Hygiene Allegany Co. 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deatl Physician/ KATHRYN MARIE RUGGLES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western MD Regional Medical Center Cumberland Allegany Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Hours 09/24/1926 Director 205-<u>16-6663</u> 85 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WV Hampshire Levels 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral HC 60, Box 36 25431 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Yes, 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Fruit Grower Fruit Orchard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Winfield Lippy Marie Sutterer Dutterer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth E. Ruggles, Sr./Husband HC 60, Box 36, Levels, WV 25431 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Omps Cremation Service 05/03/2012 Winchester 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Upchurch Funeral Home, 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause of the cause liac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be et to hours after death.

Funeral Director: After this certificate has been signed by the attending physicia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Pregnant at time of death Other (specify) Year 9 Unknown Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Acciden
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Medical State Registrar

29a. Certifie

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only o 29b. Signat

Michael

Medical Examiner: On Certifying Nurse Practione

Curran,

leted

M.D.

12502 Willowbrook Road, Cumberland, MD 32. Registrar's Signature

use of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

21502

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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and 2 Healtl tem 2:		Tina L. 20a. Method of Disp		(daughte	Place of Dispo	C 72, Box	- 1		IVI a	ysville		r Town, State	0033
permit. Page 1 and Department of Hea Important: If item: any injury or other once.		1 🛛 Burial 2	☐ Cremation 3	Removal from	State C	emetery, crer	natory or other pla	ce)		5/2/2012				WV
permit. F Departm Importa any inju once.		4 Donation 5 Other (Specify) Maysville Cemetery 5/2/2012 Maysville 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA												
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To the within To the comp.	2	only one) 3 29b. Signature and		urse Practitioner:	, to the best of f	/ .	29c. Licens	e number					as stated. th, Day, Year)	
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nas		30. Name and addre	1 Enke	shafi r	e of death (Item	23a) (Type, F	Print) WILLOW	arco	k R	d. Cur	nber	-land	MDa	11502
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:30 AM Doris J. Scrivener April 28 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Hours 1 🗆 M 2 💢 F Director 579 48 1539 79 Aug 23, 1932 West Virginia 28a-f show 10b. County 10d. Inside City Limits 10a, State 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2xx No Maryland Prince George's Fort Washington 10 10e. Street and Number Of, Zip Code 10g. Citizen of What Country? 23a Funeral 7403 Jaffrey Road 20744 United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. ō ģ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Yes 2 No Yes, Give X Baltimore, Maryland 21215-0036 1 Yes 2 No 3XX Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Restaurant. Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew H. Snell Addie B. Clinton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa L. Snell (Sister) 7403 Jaffrey Road, Fort Washington. MD 20744 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico National Cemetery May 4, 2012 Triangel, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sig atus of Funeral S rvice Lice Ferry Road, Clinton, MD 20735 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury ending physician and use as the burial-trar that initiated events resulting in death) Last Physician/Medical certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death been signed by the should be detached P.O. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has page 2 s autopsy performed? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 📈 No မှ 1 🔼 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #214, N.W., Washington, DC 20010 Yudh Gupta, M.D 106 Irving Street 31. Date filed (Mo MAY 0 3 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ 2012 Apr 24 8:00 PM M Snider Medical Homer 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Allegany Country House Assisted Living Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpiac Country MD Months Davs Hours Min. Dec 4, Director 218-12-5904 92 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits Cumberland Allegany MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 15 Cumberland Street "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐XWidowed 4 ☐ Divorced Specify: WW II white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 brick layer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Ida Evans Alonzo Snider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12415 Pine Tree Lane S.E. Cumberland MD 21502 Department of Health are Important: If item 27 is any injury or other trauonce. Allan Snider son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4/27/2012 Mt. Hermon Cemetery Cumberland MD Donation 5 Other (Specify) ionature of Juneral Service Lic 22. Name and Address of Facility all Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ ovens disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy To the Funeral Director. After this certificate h completed filled in by the funeral Air--death? 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other /13 Ø1 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 2012 Da033280 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NRS 025 Kent Ave Ste. 101

State

Registrar

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Division of Vital Records, P.O. Box 68760	Baltimore, Maryland 21215-0036
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.	per mit. Page 1 and 2 should be filed within 72 hours after death 1
Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit	sicia ledi amir

			8, n1s, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. /30/s12, State of Maryland / Department of Health and Mental Hygiene										
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rik	Director		220-52-9279 Usual Residence of Decedent	1 □ M 2 🏋 F	62	Yrs.	Months Days	Hours Will.	(Month, Day, 09/11/1			untry) rland	
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	death items ner mu		11. Marital Status	12. Was Decedent E Armed Forces?		. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ame	erican Indian,	
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21215-0036	ithin 73 ene. • than he Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	ō+)	Ìife. DO	O NOT use retired)		1	Uni	vers	itv	
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Maryland	2 shoulth and 27 is nutraum		19a. Informant's Name/Relationship James H. Schell		band	19b. Mailin 1001	g Address (Street Weires	and Number or Rura Avenue, L	al Route Number, (a Vale, M	City or Town, D 215		o Code)	
ore,	of Hea of Hea fitem		20a. Method of Disposition	Пв. и п.		ace of Dispos	sition (Name of natory or other plac	201	Date 2	20c. Location	- City or	Town, State	
Baltimore,	t. Page 1: tment of I tant: If it		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Res	tlawn	Mem. Gar	dens 04/					
Bal	per nit. Pag Der artmen Important: any injury once.		21. Signature of Funeral Service Co	ensee				ss of Facility Ad ur Street				Home, P.A.	
	344		23a. P. 1. E. ter the disease, or co shock, or heart failure. List onl	omplications that caused	d the death							Approximate Interval Between	
and the same	Physician/		Immediate Cause (Final disease or condition	a. Sersis		vndr	one					Onset and Death	
	Medical Examiner	П	resulting in death)	Due o (or as	a conseque	e ce of):						0	
	400	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	ence of):							
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0			resulting in death) Last	Due to for as a	a conseque	ence on.							
Box 68760	ath certificate be attending physici for use as the bu	Medi	IF FEMALE:	- a.						1			
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Ö.	the dealy the a	hysic	1 Yes 2 No 9 Unknown	4 ∐ Pregnant a 9 ☐ Unknown	it time or de	eath 5 L	Other (specify)						
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eco	sician: The law r certificate has b director, page 2 s	dmo							24a. Was an autopsy perform	/ led?	prior to death?	completion of cause of	
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_	nes		30. Name and address of person wh	o completed cause of d	eath (Item :	23a) (Type, Pi		sh Driv	e. Com	ark	M	CORIG am.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 12:15P M 2012 April Medical Karen Elizabeth Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Prince Georges County Hospital Hyattsville Birthplace (State or Foreign Country) If Under 1 Year If Under 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 03/26/1962 579-84-9092 Director 1 □ M 2 😿 F 50 Washington, DC Usual Residence of Decedent show 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location at Director r 28a-f s notified 1 ☐ Yes 2 X No Upper Marlboro Maryland Prince George 10g. Citizen of What Country? ö 10e Street and Number 10f. Zip Code ms 23a or must be Funeral 203 Staton Drive U.S.A. items ? Was Deceus.
Armed Forces?
Vas 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status "natural", or ite Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Sales Associate Retail Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dorothy Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Staton Drive Upper Marlboro, MD 20774 Terri Moore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Lincoln Cemetery 05/4/2012 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Service Licensee Meat good 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARBIAC ATAL RRU disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year Pregnant at time of death bed f 9 Unknown be detack signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 № No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 Yes 2 No Yes 2 director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury occurred After t 1 Natural 5 Pending work? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu M Accident Investigation Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year

30. Marne and address of person who completes cause of death (Item 23a) (Type, Print)

300

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amen#11 per FH TT 5/8/12Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 1 Month Physician/ 6 WILLIAM H. SHANKLIN toril Medical 4a Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death **Examiner** Redic 5. Social Security Number 234-60-1515 If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign . Age (In yrs. last birthday) 9. **Funeral** Davs Min. (Month, Day, Year) **Director** 1 XM 2 □ F 74 Yrs. WEST VIRGINIA 12-4-1937 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director MD **CHARLES** WALDORF 28a-f X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 5211 CELESTIAL LANE 20601 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status the Medical Examiner reed Forces?
Yes 2 No Black, White, etc ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes, Give Year or Dates "natural", Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) COALMINER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HUBERT SHANKLIN ROBERTA YOUNG injury or other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra LISA STAFFORD/DAUGHTER 4690 PRESTANCIA PLACE #112, WALDORF, MD 20601 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) FORT LINCOLN CEMETERY MAY 5, 2012 BRENTWOOD, MD 22. Name and Address of FacilityPOPE FUNERAL HOMES, P.A. Signature of Funeral Service Lic to ee MOIDS 5538 MARLBORO PIKE, FORESTVILLE, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1 Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner WOIN TITS CONGESTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). for use as the burial-transi and Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 T Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Yes 2 No **Division of Vital** 25. Was case referred to medical To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? 2 No Hospital: Other: ပ 1 Yes 1 X Inpatient 2 I ER/Outpatient 3 I DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation completely filled in by the 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗖 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 04 Physician/ 2012 Year 24 0751 Elmer Tilahman Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St.Mary's St.Mary's Hospital Leonard Town 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours Min. 05-16-1923 Maryland **Director** 88 215-16-8311 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location must be notified at Director 1 Yes 2 X No Bridgeville De Sussex 10e Street and Number ò 10g. Citizen of What Country? 23a Funeral 20389 19933 Highway Sussex USA items ? death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner med Forces?
Yes 2 \(\square\$ No Black, White, etc. ō 1 Never Married 2 Married by Maryland 21215-0036 hours after 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates Specify: 'natural", 3 ₩idowed 4 Divorced Completed Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Painter Self-employed Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Elmer Tilghman, Sr. Violet Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Johnson/Daughter 228 North Aurora St., Easton, Md. 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Federal Hill Cem 05-05-12 Federalsburg, Md. Donation 5 Other (Specify) Sign of Funeral Service Licens@e any in once. Bennie Smith Funeral Home Easton, Md. 21601 Dover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onseyand Death Immediate Cause (Final Physician/ IsnVles disease or condition Medical resulting in death) **Examiner** soque titally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 68760 the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performé 2 🗌 No 1 🗌 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes ပ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 of 27. Manner of De 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred or Attending Natural Accident Division 1 🗌 Yes 2 No Investigation the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

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State

Registrar

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30. Name and address of p

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Box 524

npleted cause of death (Item 23a) (Type, Print)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 65 Physician/ Day SAIF ULLAH 2012 15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MARGOT OCKVILLE MONTGOMERY If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months **Director** 1 **№** M 2 🗆 F 1960 INDONESIA 28a-f show 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at Director MD MONTGOMER 1 🗌 Yes 2 🔀 No ROCKVILLE 10e. Street and Number 23a or 10f. Zin Code 10g. Citizen of What Country? Completed by Funeral 2085 5010 INDONESIA MARGOT or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates ASIAN than "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) TECHNOLOGY College (1-4 or 5+) Elementary/Secondary (0-12) ROGRAMMER INFORMATION is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ AFAND1 MASNUAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSYIDI ROCKVILLE, MD. 20853 SON SOIO MARGOT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 5/02/12 MAA CEMETERY STAFFORD VA. 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licersee 22. Name and Address of Facility ADEN MUSLIM FUNERAL SER No #1070 EASY ST. WOODBRIDGE 23a. Part 1. Enter the isease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ ndancio Carcinoma 7 MC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invariant in the cause of examination and or invariant in the cause of examination and/or invariant in the cause of examination and or invari Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) MAY, 02, 2012 D0062607 or death (Item 23a) (Type, Print) eted cause Medical Phack Dr. # 200 Silver Spring. MD 20902

DHMH 17 Rev 06-2011

Registrar

Baltimore, Maryland 21215-0036

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /				/lental Hyg	giene	110	15621.
			Registrar 1. Decedent's Name (First, Middle, Last)	Certin	icate of D	eam	2. Date of Dea	Reg. No	112	3. Time of Death
П	Physicia		Robert Alfred Winters				Month	Day	Year	11:20 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b	o. City, Town, or l	Location of Death	May 1, 20	12 4c. County	of Death	11120 11
Ĵ	LAGITIII		Southern Maryland Hospital		Clinton				George	's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last be		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl		9. Birthpla	ice (State or Foreign
	Director		145 16 1564	Yrs.			July 31,		New Je	
	and show	or		own or Location	on				100	d. Inside City Limits
	Maryla 8a-f	Director	Florida Pinellas Tar	rpon Spr	rings					1 ☐ Yes 2 🎇 No
	a or 2		10e. Street and Number	1	10f. Zip Code			10g. Citizen of	What Countr	y?
	h with	Funeral	831 Riverview Lane		34689			United		
	r deal or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was	Decedent of His s, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americar ck, White, et	
036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	q pe	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Never or Dates.	1 🗆	Yes 2 No	Specify:		Specify	Whit	e
2-0	hour "natu dical	Completed			's Usual Occupat	tion uring most of work	ina	16b. Kind of B	usiness/Indu	stry
121	within 72 giene. ier than t, the Me	om	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NO	OT use retired)		9	T1 1	1.0	
Q 2	iled within Il Hygiene. I other thai vent, the N	Be C	12 2 1 17. Father's Name (First, Middle, Last)	Whasa	Communica 	I LLON 18. Mother's Nam	e (First, Middle, I		1 Gover	ment
Maryland 21215-0036	be filed lental Hy rked oth lic event	2	Roy A. Winters				a Fisher		-/	
ary	should be and Ments is marked raumatic e	3	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing A	ddress (Street ar	nd Number or Rura	al Route Number	City or Town, S	State, Zip Co	de)
Σ,	and 2 s Health tem 27		Natalie A. Winters (Wife)	831 Ri	iverview I	ane, Tarpo	n Springs	, Florida	34689	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Donation 5 Other (Specify) 20b. Place cemel 20b. Place	e of Dispositio etery, cremato	on (Name of ary or other place)	Date	20c. Location	- City or Tow	n, State
Itim	iit. Pag irtmer irtant injury	4	4 Donation 5 Other (Specify) 21. Sign vs of the real 9 vice Licensee	ington N	Vational (Cemetiery		Arlin	gton. V	irginia
Ba	permi Depar Impor any ir		maine 1	22. Na	D 1 C	Lee	Funeral H	ome,Inc 6	633 Old	l Alexandria
			23b. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter the	e mode of dying	, such as cardiac	or respiratory arr	est,		Approximate nterval Between
de l	hysician/		Immediate Cause (Final disease or condition resulting in death)	erten	Dissa	se mits	an	huth n	miz.	Onset and Death
1	Medical Examiner		Due to (or as a consist ence	ce of):		se mite		1		
		er	of any, leading to immediate cause. Enter Underlying	cotu	ictive	pulmo	nary .	Juston	4	
	ted I Insit	Examiner	Cause (Disease or injury	ral e	insull	m'e ence	,			
	te be executed nysician and he burial-transit	ΙΕχ	that initiated events resulting in death) Last C. Due to (or as a consequence	e of):	1	1				
09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	d. Diabetes							
Box 68760	eath certificate attending phy d for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							
XO	attend for us	cian	in the past 12 months?		ctopic pregnancy	′			ate of deliver onth E	y Day Year
B.	nat the death ed by the atte detached for	hysi	1 Yes 2 No 9 Unknown							
P.O.	that i	by P	Part II. Other significant conditions contributing to death but not resulting	g in the under	rlying cause give	en in Part I.				cause of death?
ds,	v requires that s been signed I should be dei	ted					12	′es 2 □ No	3 🗌 Proba	ibly 4 🗆 Unknown
CO	law re nas be e 2 sh	Completed					24a. Was a autop	sv		y findings available pletion of cause of
Be	sician: The law s certificate has t lirector, page 2 s		AC Was seen referred to modified				perfo	2 No	1 Yes 2	□ No
/ita	siciar s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatient 3	Othor	r: 4 Nursing Ho		ongo 6 🗆 Oth	or (Canaifu)	
of \	g Phy er this neral d		27. Manner of Death 28a. Date of injury 28b	o. Time of injury	28c. Injury work?	at	28d. Describe h			
lon	eath. or: Aff the fu	fica	1			∕es 2□No				
Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office		28f. Location (S City or Tow		er or Rural F	Route Number,
Ω	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e. death occu	urred at the time.	date and place, a	nd due to the ca	use(s) and man	ner as stated	1.
	ne Hoo	Medical	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my kn	d/or investigati	tion, in my opinior	n, death occurred a	t the time, date a	nd place, and du	e to the caus	e(s) and manner stated.
	Vithi Vithi Com	-	29b. Signature and title of certifier		29c. License	number		29d. Date signe	d (Month, Da	ay, Year)
	to		Dr. Fosario Fernandz		D193	518		5/1/1	2	
	14 200		30. Name and address of person who completed cause of death (Ithn 23a	a) (Type, Print)	BRAIT	of ATAS	(2/0) ('וצרדו (ו	MADO	MANY 7-7-
	Stat	te	31. Date filed (Month, Day, Year) 32. Segistrar's Signature	1000	DATE	31 1100	702	yolar,	10110	YLAND 30735
E	Registra		MAY 0 3 2012 Suma B.	par						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APR 2012 KENNETH CALVIN 11:28 A^M WALSER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WALTER REED NATIONAL MEDICAL MONTGOMERY BETHESDA CENTER If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 1 X M 2 🗆 F North Carolina Director 238 36 0874 28 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 3a or 28a-f sh t be notified a 1 Tes 2 No <u>Maryland</u> Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral . Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Fater 1 filed and 27 is marked other than "natural", or items 23a tant: If item 27 is marked other than "natural", or items 20 iny or other traumatic event, the Medical Examiner must biuy or other traumatic event, the Medical Examiner must b 7405 Fawley Ave 20744 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. Armed Forces?

1 by Yes 2 \(\square\$ No Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates. Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Ret Navv DOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cletus O. Walser Daisev Crotts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Walser (Son) 3014 Charles Street, Racine Wis 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemeterly Arlington, Virginia 22. Name and Address of FacilityLee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Se vice L Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE been signed by the attending should be detached for use. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 Other (specify) Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed or Attending Physician: The Yes 2 XNo 2 🗆 No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 🗌 Yes 2 🔀 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? s after death. Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C the Hospital Medical 1 Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD D40389 2

Registrar

X

egistrar's Signature

WALTER REED NATIONAL MEDICAL CENTER

BETHESDA, MD 20889

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DECKER.

3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 01, 2012 Physician/ 5:15M Arthur Gerald Winner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Egle Nursing and Rehab Center Lonaconing Allegany If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** (Month, Day, Year) February 14, 1924 Country) Maryland 1 X M 2 □ F Months Days Hours 218-12-5613 88 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Frostburg Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21532 19722 O'Mara Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) Service Station Owner permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Winner **Emma Hemming** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17607 Old Dan's Rock Road S.W., Frostburg, Maryland, 21532 Laurie Meredith - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date May 03, cemetery, crematory or other place)
St. Josephs Catholic Cemetery 1 X Burial 2 Cremation 3 Removal from State Midland, Maryland 4 Donation 5 Other (Specify) . Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on all chile. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner munny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for in the past 12 months? Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Yes' Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Englos 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 🗷 No certificate Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: 2 INO 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work?
1 Yes 2 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3

2 State 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

COCKNON

32. Registrar's Signaturé

29c. License number

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State		artment of Health and N tificate of Death		-2012	15637			
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	illicate of Death	Reg 2. Date of Death	. No. L. O 1 L.	3. Time of Death			
	Physicia Medic		Regina Juanita	White		April 29	Day 2012 Year	12:20 A M			
	Examin		4a. Facility Name (if not institution, give street and number, Golden Living Center		4b. City, Town, or Location of Death Cumberland		4c. County of Death	any			
Ī	Funeral		1 M 2 VE	nge (In yrs. last birthday) 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	g. Births	place (State or Foreign try)			
	Director		219-14-7125 Usual Residence of Decedent	89 Yrs.		(Month, Day, Ye 03/14/19	923 Mary	vland			
	rland f shov	tor	10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits			
	Mary 28a-)irec	MD Allegany	Cumb	perland			1 X Yes 2 □ No			
	s 23a or	Funeral Director	10e. Street and Number 511 Schlund Avenue		10f. Zip Code 21502	10g	. Citizen of What Cour USA	itry?			
တ္တ	ter death , or item aminer m	by	11. Marital Status 1 Never Married 2 Married 1. Never Married 2 Married 1. Yes, Give	?	Vas Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.			
8	ours a	eted	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		l ☐ Yes 2 🛣 No Specify:	Lio	Specify: Wh				
1215	rithin 72 h iene. r than "n the Medi	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 of 2)	(Give I life. Di	kind of work done during most of work O NOT use retired) Homemaker	ing	b. Kind of Business Ind Home	austry			
and	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Jesse Howard	Judy	18. Mother's Nam Sadie	e (First, Middle, Maid Renee		Hott			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	i (A	19a. Informant's Name/Relationship (Type, Print) James R. White / Son	19b. Mailir 6650	ng Address (Street and Number or Rur N. Lawn Avenue, I	al Route Number, Cit LOUISVILLE	ty or Town, State, Zip C e , OH 446				
nore,	age 1 and ent of Hea it: If item y or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Star 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place) m @ Rocky Gap 05/		c. Location - City or To				
Baltir	permit. P Departme Importar any injur		21. igniture of Funeral Service (Roensee		Funeral E						
			23a. Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li			Approximate					
	Physician, Medical		Immediate Cause (Final disease or condition	nay Ivi	try Discare			Interval Between Onset and Death			
	Examiner •		Sequentially list conditions, b.	s a collise of fice oil.							
	nted d ansit	Examine	if any, leading to immediate cause. Enter underlying Cause (Disease or linjury that initiated events c.	s a consequence of):							
0	aath certificate be executed attending physician and for use as the burial-transit	dical Ex	resulting in death) Last Due to (or a	s a consequence of):							
3760	ificate ig phy as the	Medi	U								
. Box 68	e death certificate be executed the attending physician and shed for use as the burial-transit	Physician/Me		at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year			
s, P.O.	s tha	by	Part II. Other significant conditions contributing to death	but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?			
Records,	2 28	Completed				24a. Was an autopsy	prior to co	osy findings available mpletion of cause of			
E Ke	sician: The law s certificate has b lirector, page 2 s		25. Was case referred to medical		26. Place of Death (Chec	performed 1 Yes 2	? death?	2 🗆 No			
Vita	ysicia s certi directo	To Be	examiner? Hospital:	itient 2 ER/Outpatien	Louis		e 6 Other (Specify,				
n ot	* Attending Physician: The le er death. ector. After this certificate he by the funeral director, page		27. Manner of Death 28a. Date of in (Month, D	jury 28b. Time of	1 1	28d. Describe how i					
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Certificate:	3 Suicide 6 Could not be 28e. Place of Ir	njury - At home, farm, streetc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,			
	e Hospita 24 hours e Funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
		-	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month, L	Day, Year)			
	5		20 Name and address of accounts	death (Ita- 20-) T - 5	Dou 33 284	<i></i>	tpr. 630	,2012			
	nds		30. Name and address of person who bempleted cause of Sunil K. Gupta, M.D.		Avenue, Cumberla	ind, MD 2	1502				
	Stat Registra		31. Date file MANTH (Parl Year) 12 32. Regist	trar's Signature							

amend 5, per fh, g927 5-16-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 5638 Reg. No. 2 U State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month . 22.28pm Physician WATSON JR. ARTHUR CLINTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Plato -a Civista Pala If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□F Yrs. Director 217-06-4412 JUNE 27,1965 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Itams 23a or 28a-f ehow the Medical Executes must be notified at 1 Yes XXNo MD Directo CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 12505 GROSSTOWN ROAD 20646 S. A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes XXNo If Yes, Give Year or Dates: AMERICAN Never Married 2 Marned 5 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced "natursi", INDIAN leted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Compl nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) LANDSCAPER 12 LANSCAPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental F ARTHUR CLINTON WATSON SR. CATHERINE DIANE PENNY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 is
eny injury or other trau CATHERINE WATSON/MOTHER 9038 PENNS HILL RD. LA PLATA MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) MAY Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2

Cremation 3

Removal from State TRINITY MEM.GRDNS. 11, 2012 WALDORF, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) nding physicien a by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပို 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation s after dea. 1 Natural 1 ☐ Yes 2 No 22109PM 112 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) Haghesville, 4026 137 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12505 Grosstown Rd. To the Hospitel of within 24 hours at To the Funerel D completely filled in at Home 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0050883 Jania M. Jagour. IUgm 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 25500 point Lockast Rd. 20656 leonar PAH.A M. TAGOUV. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 6 2012 Zenera B. parker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 27, Day 2012 Physician/ 9:51P Donald Robertson Young Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Worcester Pocomoke City 915 Walnut Street 8. Date of Birth (Month, Day, Yea June 17, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Year Hours 1932 Virginia 1 **X**M 2 □ F **Director** 38_925/ 79 Yrs Usual Residence of Decedent 10d, Inside City Limits or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director X Yes 2 No Pocomoke City Worcester MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 21851 Funeral 915 Walnut Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Food Cook 12 and Mental Hygier is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florida May Bennett ည Warner Ames Young other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other tra-915 Walnut Street, Pocomoke City, MD 21851 Joan Young/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pocomoke City, MD 5/2/2012 First Baptist Cem. 22. Name and Address of Facility Pocomke City, MD 21851 Holloway Funeral Home, P.A., 107 Vine St. 21. Signature of Fund Service Licenses FSF 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Ne shock, or heart failure. List only one cause on each line. Immediate Cause (Final Notes Privide un/ 1 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and the burial-trai Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 2 No 1 Yes certificate Yes 26. Place of Death (Check only one) To Be 25. Was case referred to medical director, examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28c. Injury at work?
1 Yes funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred s after death. Certificate: iniury 1 Natural 2 Accident 5 Pending 2 No Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner To the best of my movine growth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) Signature and title of certifie Nel Name and address of person who completed cause of death (Kem 23a) (Type, Print) losfice gistrar's Signatu State

Registrar

			Please	Type or Print in	Black Ir	ndelible Ink	. Ensure A	All Copies	Are Lec	gible.	
			For State Registrar	State of Marylan	ia / Depa <i>Cer</i>	artment of H tificate of D	leaith and N Death		giene 21	012	15640
	Physicia		Decedent's Name (First, Middle, La Michael Edward Yi		-			2. Date of Dea		2012	. Time of Death
o L	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or		05	4c. Count	y of Death	11:10 1
-	Funeral		2146 Old Washingt 5. Social Security Number 6. 8		ast birthday)	Westminst	If Under 24 Hrs.	8. Date of Birtl	Carr		(State or Foreign
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	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation		12/24/	1948	10d. I	Inside City Limits
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	ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	ath wif	uner	2146 Old Washingt	on Road 12. Was Decedent Ever in U.S	3 12 1	21157 Vas Decedent of His		poif. Voc or No	USA		
9	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by F	1 Never Married 2X Married	Armed Forces? 1 X Yes 2 □ No 19	968-	f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ce - American Inck, White, etc.	idian,
903	ours af tural" al Exa	ted	3 Widowed 4 Divorced		7/4	Yes 2 X No			Specify	White	
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and	be filed ental H ked ot c even	To Be	17. Father's Name (First, Middle, Last) Francis B. Yingli	n a			18. Mother's Nam	, ,		-/	
Maryland	should be filed within 72 n and Mental Hyglene. 7 is marked other than "r raumatic event, the Med		19a. Informant's Name/Relationship (19b. Mailin	ig Address (Street a)
e, Z	permit. Page 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone.		Nancy Yingling/wi			Old Washi					21157
Baltimore,	age 1 ant of B		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	emetery, cren	sition (Name of natory or other place	9)	Date		- City or Town,	
altii	permit. P Departmi Importar any injur		21. Signature of Funeral Service Licen	- I Cai		remation Name and Address		1/2012 Funeral	Hampst Home a	ead, MD and Char	el. P.A.
<u>m</u>	Pe B III B		Mark &		4	12 Washir	naton Roa	d, West	minster	MD 2	21157
1.5	Physician/		23a. Part 1. Enter the disease, or corresponding to the shock, or heart failure. List only of immediate Cause (Final	plications to it call sed the deat one cause	n. Do not ente	or the mode of dying), such as cardiac o	or respiratory arro	es,	Inte	proximate erval Between set and Death
-	Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequ	uence of):	204					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	uence of):						
	be executed lician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C		_					
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9 × 6	th cert ttendin or use	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live Birth 2 Feta	al death 3		/			ate of delivery	Vee
Box	the dea by the a ached f	hysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of c	death 5 ∟	Other (specify)			1010	onth Day	Year
. P.O.	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			tribute to the ca	
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of Vi	Physi r this o	은	1 Yes 2 No 27. Manner Death	Hospital: 1	ER/Outpatien	t 3 DOA Other	4 L Nursing Ho	ome 5 Resid			
on c	ending tath. rr. Afte	icate	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year) n	injury	work?	Yes 2 No	200. Describe in	ow injury occur	red	
Division of Vital	or Atter after de Directo in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not to 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Town		er or Rural Rou	te Number,
Ω	ospital hours uneral I	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of my knowl	ledge, death o	occurred at the time,	date and place, a	nd due to the ca	use(s) and man	ner as stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi		(Check only one) 3 Certifying Nur 29b. Signature and title of certifier	iner: On the basis of examination se Practitioner: To the best of n	ny knowledge,	igation, in my opinior death occurred at the 290 License	e time, date and pla	ace, and due to the	ne cause(s) and i	manner as stated	d.
	I I M		Muna	Knit	M	D3	539	8	S -	ed (Month, Day,	17
	US X. B.		30. Name and address of person who	completed cause of death (Item	23a) (Type P	rint)	3 11.0	doine	+ . 1/ Y	MD -	1167
	Stat	е	31. Date filed (Month, Day, Year)	32. Registraris Signat	ander) WITH	Jr. WW	HUIK	الالمها	1100	HD+
	Registra	-	MAY 1 6 2012	Central P. A	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 15 Physician/ 2012 11:45 A^M Alice Freida Acerno Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Harford 1401 Joppa Forest Drive Joppa Apt. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. Oct. 23 Year 1945 New York 1 M 2 TF Yrs Director 66 080-36-8033 Usual Residence of Deceder permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Director 1 ☐ Yes 2 No Maryland Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21085 1401 Joppa Forest Drive Apt. K 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. à 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Medical Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Bella (nmn) Kahn Fred (nmn) Gottschalk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 Joppa Forest Dr. Apt. K, Joppa, MD 21085 Michael Acerno / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Rose Hill Svcs, LLC 5-16-2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ur- / Funeral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ In disease or condition resulting in death) Medical Due to or s a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Day Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No isigned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy After this certificate To the Funeral Director; After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital Other: 4 Nursing Home 5 A Residence 6 Other (Specify) No Dec |2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at → Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Entifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiel 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Certifying Nurse Practioner: To the best of my knowledge, de 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

doy

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Gace 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 47 30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F Months Days Hours Min. Day Country) Director Usual Residence of Deceden 28a-f show 10b. County 10a, State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified More 1 Tyes 2 No TIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral .MQe 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examinant in any injuy or other traumatic event, the Medical Examinant. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ionuoson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Moy 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Surial 2 ☐ Cremation 3 ☐ Ren oval from State Important; l' any injury or altimore 4 Denation 5 Other (Specify) 2017 21. Sign Jury of Funeral Service Licen 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset an eath shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 400 Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted to the Funeral Director: that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Year Month Pregnant at time of death Day Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 14. 2012 7:15 PM Lucille Lorraine Bernier May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Aberdeen 838 Lynn Lee Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Dec . 18, 9. Birthplace (State or Foreign Country) Maine Biddeford 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1 931 Months Days Hours Min 1 □ M 2 🗓 F 80 Director 007-26-1552 Yrs Usual Residence of Decedent 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Harford Aberdeen 1 Tes 2 X No Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 838 Lynn Lee Drive 21001 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: White Completed 3 Widowed 4 N Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed should be filed with and Mental Hygien ris marked other th Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Viger Ida Labbe permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 B. Oakleaf Cir., Abingdon, Maryland 21009 Angela Roe Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel Forest Hill, Maryland <u> Air</u> Evans Funeral Chapel & Cremation Services - Bel Air 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3 Newport Drive, Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Dispuse of the cause Examiner Due to (or as a consequence of): Cause (Disease or I that initiated events burial-tran Due to (or as a consequence of). resulting in death) Last attending physician for use as the burial Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death ed by the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 Hospital or Attending Physician: The 24 hours after death. 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation after death Director: / filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined on 24 hours to the Funeral Discompleted filler Medical Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of certifier M.D. of death (Item 23a) (Type, Print) Name and address of person who completed cause Benjamin 669 Revolution St. 31. Date Ned (Month, Day, Year

DHMH 17 Rev 7/2009

State Registrar

Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:15 P M 2012 May 0. Burmeister Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Futurecare Chesapeake Arnold Anne Arundal 7. Age (In yrs. last birthday) If Unc 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Min Country) Director 226-16-3007 1 □ M 2 😿 F Yrs 90 Oct. 18,1921 Virginia Usual Residence of Decede or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 216 Greenland Beach Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 N/A Hutzlers Dept. <u>Sales Person</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Bazilo V. Funai Beulah other traumatic Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Vernon Dwight Burmeister (Son) 8115 Holly Road Baltimore, Maryland 21226 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Hillcrest Mem. Grdns | 05/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 22. Name and Address of Facility 21. Signature of Fuperal Service Licensee MOO-732 McCully-Polyniak F 3204 Mountain Road Home, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate has 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No filled in by the Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physiciany to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D 00 73 574 29b. Signature and title of certifier

Registrar DHMH 17 Rev 06-2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Kanmova

who completed cause of death (Item 23a) (Type, Print)
an word 8601 Vete 20us UNY, Shite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) May 15, 2012 8:48A **Physician BETTY** MERRIAM BLOCK /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Franklin Woods 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month. Day) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Hours 05/25/1922 **Funeral** Months Days 1 □ M XX F Maryland 89 218-18-5826 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10a. State r 28a-f shov notified at 1 ☐ Yes 2 No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or USA 21237 9200 Franklin Square Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2**X**No þ 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Coordinator of Special Services the permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 Is marked other ti
any injury or other traumatic event, th
once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Minnie Durbin Arthur Carlos Merriam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3421 South River Terrace, Edgewater, Maryland 21037 Mary Kathleen Sullivan Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 05/18/2012 Baltimore, Maryland New Cathedral Cemetery □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ionature of Funeral rvice Lice 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (d) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and bunial-tran Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknow signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🍎 💬 Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 page 2 s this certificate Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 1 Inpatient 은 funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After 5 Pending investigation s after de... ral Director: Atte 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide ō of the Funeral Discompletely filler 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and

30. Name and

31. Date filed (Moi

tirle of certifier

2005

and manner stated.

dress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

dowert Ct. Fallston MD 21047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 2:11 PM **Physician** BRUBAKER 2012 05 HELEN 13 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Levindale Nursing Home + Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb 7, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 214-20-5570 1 M 2 F 87 1925 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Director Lutherville Maryland Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 USA 1617 Pickett Road Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No White Specify: <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Black + Decker Elementary/Secondary (0-12) College (1-4or 5+) Tool Manufacturing 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene McGuigan Robert Vincent Hall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1617 Pickett Road, Lutherville, Maryland 21093 William C. Brubaker (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dul. Valley Mem Grdns 5/17/2012 | Timonium, Maryland 4 Donation 5 Dother (Specify) 21. Signat and Service Colored Partin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RIGHT HIP FRACTURE COMPLICATIONS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Jarolitollan M Examiner FALL CERTURISATION APPROVED BY MEDICAL EXAMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or de a cunsequence of): Examiner DEMENTIA physician and the burial-tran Due to (or as a consequence of): Physician/Medical attending properties for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ OBSTRUCTIVE DISEASE 1 Yes 2 No 3 Probably 4 Unknown PULMONARY Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate has director, page 2 : 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No မှ this 28b. Time of funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Injury 5 ☐ Pending investigation 1 Natural 05:15AM FALL FROM BED TO FLOOR 1 ☐ Yes 2 ☐ Mo 05/12/2012 2 Accident 6 ☐ Could not be

be executed Box 68760, law requires that the death certificate P.0. Division or Vital Records, Hospital

Maryland 21215-0036

Baltimore,

il or Attending Patter death.

Director: After t Certification: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2434 W: BELVEDERE AVE BALTIMULE, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide MURSING Home 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14-2012 PHYSICIAN 00064533 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVIND ALE CHATTELL 2434 W. BELVEOFILE AVE. BATTIMORE mi) 21215 BABATUNDE AJANI 22. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 4:50 AM 5 Brunson Harsen 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** Towson Manor Care Nursing Home Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 251-54-7637 1 🖳 🔏 1 2 🗆 F **Director** 76 35 SC **b**8 09 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland Director 1 🗆 Yes 2 🛣 No Windsor Mill Baltimore MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō ems 23a or r must be r Funeral U.S.A. 21244 7112 Portsmouth Road "natural", or items edical Examiner mu within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Completed Year or Dates. alth and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Arundel Truck Co. Truck Driver 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evenores. ပ Eva Mack Isaiah Brunson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 Main Ave, Catonsville, Md 21228 19a. Informant's Name/Relationship (Type, Print) Harry Brunson-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Memorial Park 5/18/2012 Woodlawn, Md 21. Signature of Fungral Service License 22. Name and Address of Facility
March F/H West
4300 Wabash Av al Ave, Baltimore, 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Vascular Accident Immediate Cause (Final erebra Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ρ Month Year Pregnant at time of death detached Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: injury 1 🔀 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) H0054424 5-14-12 Lutherull, MD 21093 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) CYTUS ASadi, 1012 Falls Croft Way

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Barks

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MA 4 Physician/ 5:25 PM Patricia Ann Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER WSON 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpi Country) MD 3-25-1949 (Month Day Year) Hours 219-50-5040 Director 63 1 □ M 2 💢 F Usual Residence of De shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 No Randallstown MD Baltimore 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9977 Tuscarora Road 211.33 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or other traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: African-American 1 ☐ Yes 2 X No Specify 3
Widowed 4
Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12th Benefit Specialist Social Security Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) 7 is marked or ပ Paul McCraw Sr. Mary West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Kia Brown/Daughter 9977 Tuscarora Rd., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ited any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Métro Crematory 5-16-2012 Baltimore, MD 22. Name and Address of Facility Wile Funeral Home P.A. of Baltimore Co. 21. Signatur f Funeral Service Lice 9200 Liberty Road, Randallstown, MD 21133 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final NEUMONI Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death been signed by the a should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 🗌 Yes 2 🕱 No 1 Yes 2 No nours after death.

neral Director: After this certification of filled in by the funeral director, p. 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State; 24 hours a 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my mowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 31189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE TOWSON, MARYLAND 21204 1601 MININSOHN M.D DSLER I,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of Health a tificate of Death		giene Reg. No. 201	2 15649				
	Physicia	an/	1. Decedent's Name (First, Middle, L		7/		2. Date of Death Month Day Year						
~ 84	Medi Examir		4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or Location of Death 4c. County of Death							
select.	Funeral		5. Social Security Number 6.	CIAC HOSPI Sex 7. Age (In yr	TAL s. last birthday)	BAMIMOR If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth		rthplace (State or Foreign				
	Director		Usual Residence of Decedent	1 □ M 2 🄼 F	98 Yrs.	Months Days Hours	Min. (Month, Day		GA				
	faryland 8a-f shc tified at	Director	10a. State 10b. County		City, Town or Loc				10d. Inside City Limits 1 Yes 2 □ No				
	ith the N 23a or 23 st be no		10e. Street and Number		9/1-1/1	10f. Zip Code 21218	T	10g. Citizen of What Co					
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Funeral	3040 BARCIA 11. Marital Status	12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican,	n? (Specify Yes or No-	14. Race - Ame					
9000	ırs after ural", or I Exami	ted by	1 Never Married 2 Married 3 Wildowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.		☐ Yes 2 No Specify:		Black, Whit	LACK				
215-0036	n 72 hou an "nati Medica	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed)	(Give A	ent's Usual Occupation ind of work done during most of NOT use retired)	of working	16b. Kind of Business					
2	iled withi I Hygiene other th	Be Co	17. Father's Name (First, Middle, Last	College (1-4 or 5+)	Hous	EKEEPER 18 Mathour	's Name (First, Middle, I	DOME.	STIC				
Maryland	uld be fill Mental narked atic eve	욘	Mc CA Mey 19a. Informant's Name/Relationship		-011	FAN	NIE ARI	DISTER					
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nore	age 1 and ant of Hea it: If item y or other		1 Maria 2 L Cremation 3	Removal from State	cemetery, crem	sition (Name of latory or other place) E CEMETERY 5	Date - /2-2/12	20c. Location - City or	Town, State				
Baltimore	permit. Page Department o Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		22.	Name and Address of Facility	VAILCIAN O	GREENE FI	NER AZ SCVS				
	TD = 60		23a. Part 1. Enter the disease, or conshock, or heart failure. List drifty	pplications that caused the de	eath. Do not ente	905 YORK RE r the mode of dying, such as ca	DAO · BA	est, MO.	Approximate				
b	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. SICK	Sinu	s Indon	ne		Interval Between Onset and Death				
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0	ate be executed physician and the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conse	equence of):								
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Box 687	death certifica ne attending p ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No	23c. If yes, outcome of preg 1 Live Birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year				
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ision	Attendi er death. ector: A by the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide description	28e. Place of Injury - At	home, farm, stree	M 1 Yes 2 N		reet and Number or Rui	ral Route Number.				
2	spital or ours afte eral Dir filled in			building, etc. (Spec		and the time date and of	City or Town						
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 Medical Examonly one) 3 Certifying Nu	niner: On the basis of examinat	tion and/or investig	ccurred at the time, date and plagation, in my opinion, death occudeath occurred at the time, date a	rred at the time, date an	d place, and due to the	cause(s) and manner stated				
	No Norit		29b. Signature and title of chriffier	MD	•	29c. License number	88	9d. Date signed (Mont)	n, Day, Year)				
			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type, Pr	INW ST SUITE	301 BAC	TIMORE MO	7 2 [20]				
I	Stat Registra	-	31. Date filed (Month, Day, Year) NAY 1 7 2	32. Desistrar's Sign	nature	and a	,		,				
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Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date	Reg. of Death		3. Time of Death
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AOY		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland 28a-f show	5	Maryland N/A Baltimore			1 Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene, ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be softlied at occess or other traumatic event, the Medical Examiner must be softlied at occess.	I Director	10e. Street and Number 10f. Zip Code 21231	10g	Citizen of What Cou	tates
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ter der ", or i		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B	lack
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21215-0036 uld be filed within 7/ Mental Hygiene, marked other than ic event, the Medical	Be C	17. Father's Name (First, Middle, Last) Alfred Brown, Sr. 18. Mother's Name (First, Middle, Last) Jacyuel	, 1		
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Balti permit. Departm Imports	Ц	21. Fign ure of Funeral Service Licensee 22. Name and Address of Facility	ns B	Sto, no	21228
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/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Gunshot Wounds			Between Onset and Death
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To the Ho within 24 within 24 completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time			
To with To con	Mec	29b Signature and title of certifier 29c. License number	2	9d. Date signed (Mo	nth, Day,Year)
		O.C.M.E.	N	May 14, 2012	
\	1	30. Name and address of person who completed cause of death (Item 23a)			
		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 212	23		
St Regist	ate rar	31. Date filed (Month, Day, Year) ANY 1 7 2012 August S. Agarts A. Agarts			

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Ser FH 6927 5/17/2012 Per Health and Mental Hygiene 1 - For State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 012 Physician/ 3:00 M Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** More If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth **Funeral** Sept. 27-31948 Hours Min Country Director 1 🗆 M 2 🖫 F 63 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 Nes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. þ Maryland 21215-0036 1 Yes 2 No Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

The Operator (Specify only highest grade completed) nit. Page 1 and 2 should be filed within 73 antment of Health and Mental Hygiene, octant. If item 27 is marked other than injury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montford Marg ue Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Department Important: If any injury or OWINGS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funeral Service 22. Name and Address of Facility toweld Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 the signed by the attending | Id be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Other (specify) 1 Yes 2 5 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3∕ Probably 4 ☐ Unknown Division of Vital Records, icate has been sign; page 2 should b 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIRNEL 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Matural 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🕵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 2012 th (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item, 30 per dvr g927 5-17-12 vt
State of Maryland Department of Health and Mental Hygiene
AMEND ITEM#20b, per FH, G928, 6/4/2012, WS
Certificate of Death

Reg. No. For State Registrar 15653 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ $20\overset{\text{Year}}{12}$ Alastair MacRae Collie 16 12:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8009 Strauff Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | Min. | May 23, 1923 5. Social Security Number 9. Birthplace (State or Foreign Country) England 6. Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday **Funeral** Months Yrs. **Director** 024-24-9771 88 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8009 Strauff Road 21204 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4 vears Civil Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi f Health and Mental မ Alexander Duncan Richardson Collie Lillian Birchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. (wife) 8009 Strauff Road Baltimore, Virginia G. Collie Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 5/17/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²², Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Road Baltimore, Maryl 23a. Part 1. Buter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Maryland Approximate Interval Between Immediate Cause (Final Onset and Death Physician. ItiAle disease or condition resulting in death) ears Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No s been signed by the selection should be detached 1 L Yes 2 L g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Part II. 23e. Did tobacco use contribute to the cause of death? ulmunati 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? completed filled in by the funeral director, page 2 certificate Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 Yes 2 / No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Man er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No ✓ Natural 5 Pending injury Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William D. McConnell 6301 N. Charles Street Suite 5 Baltimore, Md. 21212 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Manth 3. Time of Death OLEMAN ainaL 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex (Month, Day, Months Hours Min 1 **X** M 2 □ F 215-74-7777 69 MD 42 Yrs 11 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 U.S.A <u>B436 Cohasset Ave</u> 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forc 1x Never Married 2 ☐ Married Black, White, etc. Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>Sea Side Restaurant</u> Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincent O. Leggett Myra Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3436 Cohassett Ave, Annapolis, Md 21403 Vincent Leggett-Father 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Memorial Park 5/21/2012 Woodlawn, Md 22. Name and Address of Facility

March F/H West

Physician/ Medical **Examiner**

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

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"natural", or items

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once."

Director

Funeral

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Completed

Be

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the Maryland

permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examine burial-trar the attending physician Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this certificate has been signed by the attending natural vision. as ase s pe Medical Certificate: To completely filled in by the funeral

Division of Vital Records, P.O. Box 68760

John VI	acco	14300	Wabash Ave	Baltimo	re. Md	21215
23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the death. one cause on each line. a. Due to (or as a sin nseque	Do not enter the mod	de of dying, such as cardiac			Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ince of):				
that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnand 1 Live Birth 2 Fetal (4 Pregnant at time of de	death 3 Ectopic			23d. Date of de Month	livery Day Year
Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying	cause given in Part I.		*	the cause of death?
				24a. Was an autopsy performed'	prior to death?	topsy findings available completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient 3 □ [26. Place of Death (Chec	ome 5 Residence	6 Sther (Spec	TO CO
27. Mannar of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	jury occurred		
3 Suicide 6 Could not 4 Homicide determined		ie, farm, street, factor	y, office	28f. Location (Street : City or Town, Sta		ral Route Number,
(Check 2 Medical Exam	ysician: To the best of my knowled niner: On the basis of examination a rse Practitioner: To the best of my	and/or investigation, in	my opinion, death occurred a	at the time, date and pla	ice, and due to the	cause(s) and manner stated
20h Signature and title of certifier		20	a Lineana number	00.1.1	D-1	- D VI

DIS872 May 15, 2012 Blud Spon BURATA 21061

DHMH 17 Rev 06-2011

State Registrar

the within To the 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 11,2012 11:41 Carolia Q. Clark Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 903 Lake Front Drive Prince George's Mitchellville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) Director 219-12-3902 1 🗆 M 2 🕱 F May 18, 1924 Maryland Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's 1 Yes 2 X No Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 903 Lake Front Drive 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give 3 X Widowed 4 Divorced ^{Specify}African A<u>merican</u> Completed Year or Dates 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ injury or other traumatic Rufus Oueen Columbine Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Sharon James/ Daughter 12610 Kings View Street Mitchellville, MD 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/16/2012 | Hyattsville, MD Harmony 4 Donation 5 Other (Specify) 21. Signature of Fameral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sonile Immediate Cause (Final several years disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 as attending place as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been sig 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perforn certificate 1 Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certificately filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the comple only one 022780 2012 20 cause of death (Item 23a) (Type, Print) 500 Greenway Ctr Dr. Weenhelf, 40 20770 21 31. Date filed (Mont Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Deborah Ann Christian State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner Deborah 3. Time of Death Ann Christian 0228 hrs May 12, 2012 4a. Fecility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min. Foreign Country) 216-74-2254 1 M 2X F 52 Yrs. 10 20 59 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once, 28a-f sho permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 West Belverdere Ave #307 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? White etc. Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year ě 1 Yes 2 No specify: Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Caton Manor 12th grade na Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be John E. Christian Jean L. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Ervin-Daughter 4813 Eldon Green, Baltimore, Md 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify King Memorial Park 5/22/2012 Woodlawn, Md Signature of Funeral Service Licenses Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and /Medical mmediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Disease Examine Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed after death. and Physician/Medical AMENDED 23a, 27, per me, g927, 5-18-12 sm attending physician or use as the burial X UNPENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death past 12 months? 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown Records. After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 Yes 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural Director: 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after To the Funeral Dire 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City determined or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. May 12, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Physician/ INGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BAUTIMORE ge (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 4Yrs. Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f sho important: I firem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No BALTIMORE MD 10e. Street and Number 10g. Citizen of What Country? Funeral ATSQUITH 21202 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) BANKING MANAGER Be Father's Name (First, Middle, Last arrington mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ISQUITH Baltimore, 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State BAUTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) GREENE FUNERALLOVS 21. Signature of Funeral Service I cens etimore, MO. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was al. autopsy performed? 24a Was an 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} Hospital Other: Certificate: To 2 📝 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Deth 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending within 24 hours after deau.

To the Funeral Director: Aft Natural Natural 1 🗆 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Weitcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title d

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEVEVER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15658 Certificate of Death Reg. No 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2012 Year 9:35 A Physician/ May Alvin Turner Church Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice Birthplace (State or Foreign Country)
 NC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) n 2 Ye **Funeral** 1 M 2 □ F Months Days Hours 1948 March 64 Director 216-44-6109 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f shov 10a. State must be notified at Director filed within 72 hours after death with the Maryland 1 Yes 2 No Cockeysville Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Numbe 5 Funeral USA items 23a 21030 7 Moorepark Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Examiner 1 Never Married 2X Married white ŏ þ 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Yes, Give 3 Widowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) BG&E Gas Surveyor 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Ruby Church မ Adam Turner Church 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 Moorepark Ct., Cockeysville, MD 21030 Mary Church/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 5/18/Pf2 20a. Method of Disposition or other place) 1 XBurial 2 Cremation 3 Removal from State Timonium, MD Dulaney Valley Memorial Gardens 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Europal Service Licensee Michael Flagle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cell Carcinom Sanwors Physician/ met share disease or condition resulting in death) Due to (or as a consequence of) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Day Month in the past 12 months? signed by the a Yes 2 No 1 ☐ Yes 2 L g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performed? Yes 2 No 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Wisput Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 No |၉ 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 thin 24 hours after death. the Funeral Director: After this certificate

> State Registrar

Certificate:

Medical

27. Manner of Death

1 Natural

29a. Certifier (Check

only one)

Accident
Suicide

3

ature and title of certifie

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

within To the

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

0

28c. Injury at

work?
1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DS8203

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day, Year)

2012

28a. Date of injury (Month, Day, Year)

Begistra Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 14, 2012 7:45 P Jeanne Margaret Cross Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Towson Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Hours Days Min 94 Maryland **Director** 212-12-7359 May 1918 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🗌 Yes 2 🄀 No Harford Maryland Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3329 Garrison Circle 21009 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Roofing Company Payroll Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file 2 Wilmer T. Matthews Frances (unk) Large 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 205 Secretariat Drive, Unit B, Havre de Grace, MD Douglas Cross / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5-21-2012 |Bel Air, Maryland Svcs, LLC 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phynician neumonia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or imjury that initiated events -trar and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy performed? death? 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 100 Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours after City or Town, State) 29a. Certifier 🕯 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) har

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERRELL CLARK MAY 1030 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORECITY IA 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 212-90-45 (Month, Day, Year) Director 1 M 2 □ F ma March and idence of Decedent or than "natural", or items 23a or 28e-f shover the Model Experient must be notified at 10c. City, Town or Location Directo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene, tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 20 1 or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healt Important: If Item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and A dress of Facility hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Meningitis disease or condition resulting in death) Medical Due to (or as a con uence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ettending physician and I for use as the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death sate has been signed by the epage 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a Was an After this certificate has autopsy 1 Ves 2 □ No 2 🗌 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🛂 No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **RES** 000 of person who completed cause of death (Item 23a) (Type, Print) 800 ORLEANS STREET BALTIMORE MD 21287

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Red

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 - 14 Day 11.99r Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Battimore TOJOICO 110 N 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign -88-7620 Country) Director 1 🗆 M 2 🖫 🗗 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Himore 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SA 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black "natural", If Yes, Give 3 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only high I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) ccounting Be 17. Father's Name (First, Middle, Last) 18. Moth er's Name (First, Middle, Maid ould be file nd Mental I marked o မ Knight .,Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 if Health Baltimore other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or of 1 Deurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatural Service Licer Name and Address of Facility and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metastatio Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a sonsequence or): To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☑ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No. 2 🗌 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 🛠 Other (Specify) 2 5 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4b per doc g930 8-13-12 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death 3. Time of Death Physician/ Paul Darden 12:40 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Home **Baltimore** 9. Birthplace (State or Foreign Country) North 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Director 240-44-2414 80 1 🔀 M 2 🗆 F May 17,1931 Carolina Usual Residence of Decedent , or items 23a or 28a-f show iminer must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21206 5221 Anthony Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Self Employed Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic 8th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clair Jesse Darden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cornell MOrrison 5221 Anthony Avenue Baltimore MD.21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest 20c. Location - City or Town, State 5/22% 20c. Location - City or Town, State
Vet. Cemetery Owings Mills, Md. 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) f Funeral Service Licely ee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore MD.21206 ulles Harris 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth
Pregnant a
Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 2 🗌 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2. No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suice 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28987 rection 5-16-2012 who completed cause of death (Item 23a) (Type, Print) 2 L M.D 5601 ING LOCH RAVEN BLUD

State Registrar

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G927, 5/17/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ MAY Month SAMUEL 2012 FAGAN 15 1:58 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE 4730 ATRIUM COURT, #360 OWINGS MILLS If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral 1 M 2 □ Days (Month Day 1922) Director 213-16-3535 90 Yrs. MD Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important. If item 27 is marked other than "natural", or items ??? any injury or other traumatic event, the Maryland once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, #360 21117 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 XMarried 1 Yes 2 XNo Specify. If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 REAL ESTATE SALES REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HARRY HYMAN **FAGALMAN** IDA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONIA SHIRLEY FAGAN/DAUGHTER ATRIUM COURT, #360, OWINGS MILLS, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ANSHE NEISEN CEMETERY 05/17/2012 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 12 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Colonery 20-30 yrs Atherosclerosis Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events us to for as a managements of the attending physician and hed for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>S</u> Kidney Dises 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate has 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o certifier 29d. Date signed (Month, Day, Year) 15/2012 D0054717 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LuThe rulk 10755 Falls Re Suite 200 RAMEEN MOLAVI, MD 21093 32. Registry's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh g928 6-18-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ M_{av}^{Month} Day 2012 Year Umberto Fioravante 15, 12:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore County Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Director 1 🖾 M 2 🗆 F 219-38-1542 85 11-04-1926 Usual Residence of Decedent Italv en "naturel", or items 23a or 28e-f show Medical Examiner must be notified at within 72 hours efter death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Baltimore City Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6215 Fair Oaks Avenue 21214 <u> Inited States</u> 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. à 1 Never Married 2 Married Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Specify: White 3 KWidowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) If It io. 19.

It. Page 1 and 2 should be fliad within 72 ho artmant of Health end Mental Hyglene.

Annualt: If Itam 27 is marked other then "in and a sent, the Med 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Tailor Clothing Shop Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Allegrina DiBenedetto Fioravante Carmine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 Glenoak Avenue Baltimore, Maryland 21214 Daughter Luciana Beach 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 a
Department of H
Importent: If its
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Tother (Specify) Entombment Parkwood Mausoleum May 22,2012 Baltimore, Maryland 21. Signature of Any Vice L 22. Name and Address of Facility 5305Harford Rd. Leonard J. Ruck, Inc. Baltimore, Md. 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ement Medical resulting in death) Du o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury Examine Due to (or as a consequence of): To the Hospitel or Attanding Physicien: The lew requires thet the deeth certificate be axecuted within 24 hours effer death.

To the Funsrel Director: After this certificate has been sinned by the Author Leader. been signed by the attending physicien and should be detached for use as the buriel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Vear Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? r this certificeta hes bararal diractor, pege 2 sl 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 NN Yes ours efter death.

srel Director: After this certific filled In by the funaral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spe 1 🗌 Yes 2 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Nitle of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar AARON

31. Date filed (Month, Day, Year,

MIES

701 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 20<u>12</u> Physician/ FEDOCK MAY 13 8:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RIVERVIEW NURSING FACILITY **ESSEX** BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 9 4 234-32-2212 1 □ M 2 🕱 F Months Davs Hours Min 2-Manth Day Year) 8 W. Country IRGINIA **Director** Usual Residence of Decedent show 10b. County filed within 72 hours after death with the Maryland al Hygiene. 10a. State items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7704 PHILADELPHIA ROAD 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify 3 Widowed 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filec tment of Health and Mental H rtant: If item 27 is marked otl ijury or other traumatic even ပ ALVA SMITH URSULA STOUT 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE CECH/DAUGHTER 2921 ALCONBURY CT ABINGDON, MD 21009 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place ★☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or GARDENS OF FAITH 5-17-12 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE.MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ pertens disease or condition resulting in death) Medical Due to (or all a consequence of **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transi Coyor ~Q.V Due to (or as a consequence of) Physician/Medical mentic Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Li retail 3-2.
Pregnant at time of death
Unknown in the past 12 months?

1 Yes 2 No Month the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 No After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific M.0 00055171 14/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar Sebastian John

31. Date filed (Month, Day, Year)

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3023

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OWERS Physician/ 11-40 AM MAY 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HAVEN NURSIN ATONEVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 1 M 2 D F 24 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or lother traumatic event, the Medical Examiner must be notified at any injury or poly. 10c. City, Town or Location 10d. Inside City Limits Director 1 les 2 No 10e. Street and Number 10g. Citizen of What Country? by Funeral 2121 702 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married Yes 2 Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give a 3 Divorced 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unik Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) buardia Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 5 Other (Specify) saltimoso 4 Donation Funeral Service Li 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Physician/ THEROSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No been signed by the should be detached 9 Unknown 9 Unknown P.O. 1 Part 🖍 **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o q Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown BSTRUCTIVE RONIC 24b. Were autopsy findings available 24a. Was an this certificate has by prior to completion of cause of death? performe 2 1 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 / No Hospital Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manna of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 / Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and ti 29c. License number JE186 aun nos 30. Name and address of person who completed cause of death (Item 23a) (Type, WINGS MUL MA HIT ASNEEM 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12:33AM Diane R. Gordon May 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Gilchrist Center Howard County Howard Columbia 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Months Hours Min. (Month, Day, Year) 389-40-3763 1 □ M 2 🛱 F 74 Yrs. 1938 March 20. Wisconsin Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 1 🗌 Yes 2 💢 No Howard Maryland Columbia 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 5418 White Mane 21045 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 🛱 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) University Of Maryland 5Ť Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Kaercher Herbert Riedemann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 White Mane Columbia, Maryland 21045 Martin Gordon, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/16/12 Metro Crematory Inc. Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, 21. Signature of Funeral Service Licersee Thomas Gregor Inc. Marvland 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions it any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Day Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

as the burial-tran physician or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use þ has page 2 the funeral director, this s after death. I Director: After t To the Hospital

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Funeral

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Baltimore, Maryland 21215-0036

þ Certificate: To Be Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MAY16, 2012

coumbit, Mb 21044

State Registrar

DANIEUE 6336

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBERMAN, MO

29b. Signature and title of certifier

164395

CEDAR LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012^{Year} Physician/ 11:14 Рм Destry Allan Gastgeb May 13 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 192-62-4553 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Hours 45 **Director** 1**X** M 2 □ F 3/14/1967 WV Usual Residence of Decedent show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Bison St. 21787 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force 1 Never Married 2 Married Completed by Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify i Hygiene. other than "natural", Specify.white 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Dry Waller 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ္ Wayne R. Gastgeb Beverly A. Otzelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Nelson-wife 21 Bison St., Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) South Carroll Crem 5/19/12 Sykesville, MD 22. Name and Address of FacilityFletcher Funeral Home 21. Signature of Funeral Service Licenses D Komos 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respirat, ry arrest neach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Examin executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsv Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural injury 5 Pending Division s after death.

I Director; Afted in by the fur Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours Funeral To the Hospi within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29c. License number pleted cause of death (Item 23a) (Type, Print) Registrar

DHMH 17 Rev 06-2011

12-03699 Walter Gray

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 15670 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) 3 Time of Death Month Day May 14, 2012 Medical Examiner 1541 hrs Walter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5234 Linden Heights Avenue Baltimore 9. Birthplace (State or Foreign May Country) 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/Y **Funeral** Months Days Hours Min. Director 218-60-3701 and 1 X M Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a State 10c. City. Town or Location 1 Yes 2 No tomorr Wd Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28s-f sho Director 23a or 28a-f notified at o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 Funeral 2. Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 2 No Yes Specify: Black If Yes. Give Yeer 1 Yes 2 No specify: 3 Widowed 4 Divorced ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Baltimore, MD 21215-0036 9 abore 18.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last Be Father 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cemejer 4 Donation 5 Other Specify 20 Name and Address of Service acility/ Part I. Enter the disease, or complications Approximate Interval Between Onset and **Physician** nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory failure. List only one cause on each line /Medical aNarcotics (Morphine) and Ethanol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last й the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical \mathbf{x} AMENDED #1,23a,27,28a-f, per me,g928 6-19-12 sm **X** UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown has been sign 2 should be c Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No After this certificate 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural unknown Director: d in by the f Pending 1 Yes 2 X No 2 Accident fd_5-14-12 fd 03:30 pm Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be or Town, State) 5234 Linden Hgts. Ave Baltimore.MD. determined (Specify) To the Funeral Found: Residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mess. O.C.M.E. May 15, 2012 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ana Rubio MD. 31. Date filed (Month Da State 2012 Registrar

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Veal 925 Medical DI 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A 6 1 1t, MOR 7. Age (In vrs. last birthday) If Under If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🔀 F 215-64-9570 55 0497444 1957 Maryland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD N/A Baltimore ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5710 The Alameda Apt A 21239 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 0 1 X Never Married 2 Married Yes 2 XNo Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black "natural" Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education Baltimore City (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide School System years Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Addison Margaret Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaKeysha Marshall (Daughter 5710 The Alameda Apt A, Balto., MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State on-site Crematory 4 Donation 5 Other (Specify) 117/12 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph Adress of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a constituen of) Examiner was stirilly liet eye. This is Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical death certificate be Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death be detached signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No Yes Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to redical Be 26. Place of Death_(Check only one) examiner? Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 🗀 Pending Accident 1 Yes 2 🗆 No Investigation Could not be To the Hospital or Attend within 24 hours after death To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one and title of certifier 29b. Signature ss of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. SHATE Of Mary and reparting of the air and wenter Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY 1^{Day} 2012 LESLIE HARLAN 09:25A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 522-82-0353 1 X M 2 T F 57 10/31/1954 CO Usual Residence of Deced or 28a-f shov 10b Count 10c. City, Town or Location 10d. Inside City Limits the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If them 27 is marked other than "reconstruction of other traumation of the process." 21136 **USA** 12509 FELLOWSHIP COURT 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: WHITE 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 ENTREPRENEUR TELECOMMUNICATIONS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HARLAN ERNESTINE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMY HARLAN/WIFE 12509 FELLOWSHIP COURT, REISTERSTOWN, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 Burial 2 A Cremation 3 Removal from State CARROLL CREMATION, INC 05/17/2012 4 Donation 5 Other (Specify) HAMPSTEAD, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Dice 6 Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pendina injun work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only on 3 Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) D007(287 Name and address of person who completed cause of death (Item 23a) (Type, Print) St. # 4/05, Baltimere, 6701N. wakeen. Cherles State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 2012 HOLTZMAN 03:04PM BERNARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL WESTMINSTER DOVE HOUSE AT CARROLL HOSPICE Birthplace (State or Foreign Country) Social Security Number Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours 217-18-5212 **Director** 1 X M 2 □ F 88 02/23/1924 MD or 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MD CARROLL FINKSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21048 USA 3317 DANDELION DRIVE death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. rmed Forces?

X Yes 2 No Black, White, etc. or 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha INSURANCE SALESPERSON Be any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ SADIE LAPINSKY CHARLES HOLTZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3317 DANDELION DRIVE, FINKSBURG, MD 21048 Page 1 and 2 NATALIE HOLTZMAN / WIFE 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 05/16/2012 REISTERSTOWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., Signature uneral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition resulting in death) Medical Due to (as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-Completed by Physician/Medical P.O. Box 68760 the phy as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death both not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 🗌 Yes this certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Special Control of the 2 🗖 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After Natural 5 Pending injury Yes 2 No Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only of 3 29d. Date signed (Month, Day, Year) 29b. Signat and title of certifier State Registrar

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	Examin	er	4a. Facility Name (if not institution, give	street and number		4b.	City, Town, o	r Location of Death	'	4c.	County of Dea	th
45,	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last bir		Jnder 1 Year	If Under 24 Hrs.	8. Date of Bi			thplace (State or Foreign
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	and show	b	10a. State 10b. County		10c. City, Tow	n or Location	1					10d. Inside City Limits
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	a or 2		10e. Street and Number			10	f. Zip Code			10g. Citiz	zen of What Co	ountry?
	h with	Funeral	437 Sudbury Roa	d				21090			U	.S.A.
	deatl ritem nern		11. Marital Status	12. Was Decedent E Armed Forces?		13. Was I If Yes	Decedent of H specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 1	14. Race - Ame Black, Whit	
036	filed within 72 hours after death with the Maryland the Hygiene. A thygiene and either than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🙀 I If Yes, Give Year or Dates.	No		res 2X No				2 16	hite
21215-0036	72 hour	Completed	15. Decedent's E (Specify only highest gr		168	(Give kind o	Usual Occup	during most of worl	king	16b. Kir	nd of Business	/Industry
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Maryland	ould be fi d Menta marked matic ev	မ	George Venit					Emily Cl	nolish			
lan,	shc is au	1	19a. Informant's Name/Relationship (T	vpe, Print)	191	b. Mailing Ad	dress (Street	and Number or Rui	rai Route Numb	er, City or 1	Town, State, Zi	o Code)
	2 ± 2 ± 2		Mr. Mark Hergan	/ son		1805 F	a1staf	f Court,	Bel	Air,	Mary1a	and 21015
	ge 1 and it of Hea If item or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 C	Removal from State	cemete		or other plac		Date	1	cation - City or	
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Ва	permit. Page 1 a Department of I Important: If ite any injury or ot once,		21. Signature of Funeral Service Licens	Van	M0135			ss of Facility 1 Funeral 8	2nd Av			Burnie, MD es, P.A.
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ومسده	Examiner		resulting in deatily	Due to (or as a	consequence	of):	6					21
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m i	requires that the del been signed by the a should be detached	hysi	1 Yes 2 No 9 Unknown	9 Unknown	time of death	3 🗆 0 แ	er (specify) _					
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ds,	quires en sig ould b	edt	Pancreatic	Cancer					1 🗆	Yes 2	□No 3□P	robably 4 Unknown
Vital Records,	aw rec as bee	Completed							24a. Was			topsy findings available completion of cause of
Rec	sician: The law is certificate has bilirector, page 2 s	No.							auto perf	ormed?	death?	s 2 No
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ָם פַּ	Ing P	ate:	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of injury (Month, Day,		Time of injury	28c. Injur work	₹?	28d. Describe	how injury	occurred	
Sioi	or Attending P s after death. I Director; After t d in by the funers	Certificate:	 ✓ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b 		v - At home fa	Norm street fa		Yes 2 □ No	28f Location	(Street and	Number or Pu	ral Route Number,
Division of	al or A s after Il Dire		4 ☐ Homicide determined	building, etc.	(Specify)	, 05, 000, 10	lotory, omoo			wn, State)	Number of Hu	rai rioute Nambel,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Phys	sician: To the best of n	ny knowledge,	death occur	red at the time	e, date and place, a	and due to the o	ause(s) an	d manner as si	ated.
1	tne H hin 24 the Fi nplete	Me	only one) 3 L Certifying Nurs	ner: On the basis of ex- se Practitioner: To the	best of my kno	or investigation wiedge, deat	n, in my opinion occurred at t	on, death occurred a the time, date and p	it the time, date lace, and due to	and place, the cause(s	and due to the s) and manner a	cause(s) and manner state is stated.
	0 wit		29b. Signature and title of certifier	La union	-hms		29c. Licens				signed (Monti	
			- 10000 M	Jorlings	Or Mes		V 003	2022		1444	15 20	, -

State Registrar

3001 South Hanover Street Pultrace Mayland 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JENKS ARRELL à Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 607 Tunbridge Road Baltimore City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months **Director** 187-48-2229 May 9, 1 🕅 M 2 🗆 F 54 1958 New Mexico 28a-f show 10b. County 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 10d. Inside City Limits Maryland N/A 1 X Yes 2 No Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 607 Tumbridge Road 21212 USA permit. Page 1 and 2 should be filed within 72 hours after death \
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working US Department of life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Foreign Service Officer State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Zoya Elaine Hochstein George Merritt Jenks 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Thelma C. Jenks (Wife) Tunbridge Road, Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Green Mount Crematory 5/16/2012 Baltimore, Maryland Sign Wre of Fiveral Solving Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC.
6500 York Road, Baltimore, Maryland 21212 Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy perform 2 No 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' after death. 1 🗌 Yes Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $M_{ay}^{Month} 9, 2012$ Bessie Taylor Jackson 12:10 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min (Month, Day, Year) Director 1 □ M 2 🖾 F 228-26-2307 89 Yrs Virginia 8/28/1922 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 No Takoma Park Maryland | Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20912 United States 7401 New Hampshire Ave #320 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 Homewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Alfred Taylor Alma Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or attention 20912 7401 New Hampshire Ave #320, Takoma Park, MD Alfreda Jackson-Tanner Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Berial 2 Cremation 3 Removal from State 4 Donation 5 D Other (Specify) 05-17-2012 South Hill, VA Taylor Family Cem 21. Sign ture of Funeral Service Linensee Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) trale colitis requires that the death certificate be executed and that initiated events Due to (or as a consequence of resulting in death) Last physician at s the burial-1 Physician/Medical Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ g ☐ Unknown Linknown P.O. been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ demento 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined hours after within 24 hours a

To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2012 D174000

Registrar

7600

Carroll

Ane Takonalack, ND 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 26,28e per doc g927 5-17-12 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Dorothy Louise Johnson 201 8:15p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3710 Hillsdale Road Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months (Month, Day, Year) Days Hours Min. 212-28-7898 **Director** 1 □ M 2 🕇 F Yrs 05 83 29 VA 12 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location with the Maryland must be notified at Director 10d. Inside City Limits MD 1 XYes 2 No NA Baltimore 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3710 Hillsdale Road 21207 U.S.A. items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black 3 ₩ Widowed 4 □ Divorced Specify: Completed marked other than "natur matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha 12th grade Nurse Private Duty Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ္ John Allen White Geneva Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamara Johnson-Daughter 3710 Hillsdale Road, Baltimore, Md 21207 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) = 5 cemetery, crematory or other place) Important: If any injury or once. 5/11/2012 Baltimore, Md Baltimore National 22. Name and Address of Facility
March F/H West 21. Signature of Fund al Service WI 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Metastatic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy fo 5 Other (specify) Pregnant at time of death Month Day Year ed by the a 1 Yes 2 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate I 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မှ 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 1 Natural 2 Accident 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending s after death filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di HOSPITE Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Miller 2401 West Belvedere Ave, 21215 Mark Baltimore, Md32. Regist State

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Jeffrey 19 05 Medical SOLL 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death N/A Social Security Number Ltimar 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) Director 217-62-1299 1 X M 2 🗆 F 59 Yrs 02-02-1953 Marvland Usual Residence of Decedent 28a-f show 10a. State ms 23a or 28a-f shoms must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 Broadway 807 Ε. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Master Electrician General Motors Co. Be snould be file th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Billie M. Jecelin <u>William H. Jolly, Jr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs. Kathleen C. Jolly - Wife E. Broadway Bel Air, MD 21014 807 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Hilltop Service Corp. 05-21-2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. m Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or help allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Large Medical Due to (or as a consequence of) Examiner NS Vas Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 use as the attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 1 Yes 2 9 Unknown To the Hospital or Attending Physician: The law requires that the orthin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.O. been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 2 TNo Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 1 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 1 Natural 5 Pending worl 1 Yes 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 5/14/2012. Les 001 10 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ot maryland MD University

DHMH 17 Rev 06-2011

State Registrar 2

31. Date filed (Month, Day, Year)

12-03641	
Tyrone Johnson	

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	4a. Faci	lity Name (it)1 Sincla		n, give street	and number))			Town, or L more	ocation of [. County of D	eath		
Funeral Director		Security N -48–67		6. Sex		je (In yrs. Ia	ast birthday) 4 Yr	Mont	der 1 Year hs Days	If Under 2 Hours	24Hrs, Min.	8. Date of Bir 9–28-			Birth oreign Cour	MT	
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MD 21.	19a. Info	ormant's Na	me/Relationsl	nip (Type, Pr nier	^{int)} Sis	ter	18	-	•	and Numbe		al Route Num 1timor				Zip Code)	ų,
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Realth and Mental Hygene. Important: If tiem 27 is marked other thin injury or other traumatic event, the Medi	1 X		Cremation		noval from St	ate Eas	Place of Dispo crematory or c stern S	sition (Na ther place NOTE	ame of cem Vet	cem 5)ate -2012		Location - Ci Hurloc	•		
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	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):																
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P.O. BGs that the desgreed by the statement of the statem	Part II.	Other signi	icant conditi	ons contril	outing to deat	th but not re	esulting in the	underlyin	ig cause gi	ven in Part	l.			use contribu			
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Division Spital or Attendi hours after death. tector: /	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide Homicide Month, Day, Year) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) (Specify) (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State)								al Route Nu	ımber, City							
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Н		e and addr a Rubio I				miner 9	900 W. Ba	ltimore	Street, I	Baltimore	e, MD :	21223					
Stat Registra			h, Day, Year)	112	3. Registra	ar's Signat	ire Lau	w									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHN **JOSEPH** KREJCI Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death WSON SAINT JOSEPH MEDICAL CONTER 5. Social Security Number unk 6. Sex If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) g. Birthplace (State or Foreign Hours 1 □ M 2 □ F Country) Director 01/18/1923 Maryland 89 Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2XX No Baltimore Marvland | Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21212 7006 Copeleigh Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1XXYes 2 NoKorea Black, White, etc. 1 Never Married 2XX Married by Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Medical Doctor Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Kreici Catherine Doemling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Madelyn Krejci Wife 7006 Copeleigh Road Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State GreenMount Crematory | 05/16/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service Licenses 22. Name and Address of Fartichell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one c Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine that the death certificate be executed burial-tran that initiated events resulting in death) Last ysician Physician/Medical Box 68760 as the nding IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? 2 No 1 Yes director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 2 🗆 No Accident Investigation filled in by the 24 hours after deat Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: Tythe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pretitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) 30. Name and a of person who co BA551 M.D. USLER ou

Registrar

State

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $\mathbf{M}\mathbf{A}\mathbf{Y}^{\text{Month}}$ DOROTHY MARIE KANE 2012 10:30A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6229 COMMONS ROAD ROSEDALE BALTIMORE Social Security Number . Age (In yrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Days 219 30 0559 Months Hours Min. 02921 1936 **Director** 76 MARYLAND Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Completed by Funeral Director MD BALTIMORE ROSEDALE 1 Yes 2 XNo 10e. Street and Numbe 10f Zin Code 10g. Citizen of What Country? 6229 COMMONS ROAD er than "natural", or items 23: the Medical Examiner must I 21237 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐ Xo Specify. Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY Elementary/Seconday (0-12) College (1-4 or 5+) CLERICAL HOSPITAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MADELYN M • ROLAND Т. 2 PHELPS KELLNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, THOMAS W. KANE/ HUSBAND 6229 COMMONS ROAD ROSEDALE, 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any injury or of once. 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MEADOWRIDGE MEM. 5-16-2012 4 Donation 5 Other (Specify) ELKRIDGE, MD Signature of Fune al Se vice Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SKD disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** COPD Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy this certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) s after death. 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed

31. Date filed (Month, Day,

cause of death (Item 23a) (Type, Print

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23a per doc 9927 5-17-12 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY^{Month} LANASA M 2012 2:00 P M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner County of Death FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL, MD Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, **Director** 86 1 🗆 M 2 🕱 F 204-16-9764 Nov. 30, 1925 Scotland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 555 S. Atwood Road Apt. 216 21014 United States 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be Department of Health and Mental H
Important: If item 27 is marked ott
any injury or other traumativ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Roger Murphy Margaret Rae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda LaRue / Granddaughter 1425 Dalewood Dr. Jarrettsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 95. cemetery, crematory or other place)
Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2012 Parkville, Maryland Name and Address of Faculty Laboration Service-BelAir Dava 3 Newport Drive Forest Hill, Maryland 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Systemic Inflammatory Response Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) signed by the at d be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown encephalopany-24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 🗌 Yes Yes 2 No filled in by the funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29c. License number 29d. Date signed (Month. Day, Year) De 150 737257 may 11, 2012 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 BEL AIR, MD 615 W. MACPHAIL ROAD DAVID DUNN

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 5:27 P M Frances Theresa Lederer May 14 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium, MAryland Baltimore Stella Maris Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 217-22-3372 Director 1 M 2 X F 89 Mary land March 7, 1923 Usual Residence of Deced and Mental Hygiene. le marked other than "natural", or Items 23a or 28a-1 ehto aumatic avent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 □ No Baltimore City Marvland BaltimoreCity 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21205 945 Armistead Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: White 3 🙀 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Own Home 6 years Homemaker Be 17. Father's Name (First, Middle, Last) Department of Health and Mental h. Important: If itam 27 is marked ot any injury or other transcentiations. 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Uvilga Frank Franczkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Bessemer Avenue, Dundalk, Maryland 21222 (Daughter) Alexandra M. Jackson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/17/12 Ho1y Cross Cemetery Baltimore, Maryland Signature of Funeral Service Lice Duda-Ruck Funeral Home of Dundalk, Inc. Justin Jones 7922 Wise Avenue Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

FRANCES LEDERER Division of Vital Records, P.O. Box 68760

2012

Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** ၉ 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TRACIE L. MORGAN, **CRNP** TIMONIUM, MD 21093

Registrar DHMH 17 Rev 06-2011

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Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene

Amend Item 20b per fh,g927,05/22/2012dhb
Certificate of Death
Reg. No For State Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ PM 7.00 RUTH THELMA MILLS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAL OF BALTIMORE N/A Social Security Number 6. Sex Date of Birth 9. Birthplace (State or Foreign Birthpus Country) **Funeral** RKth. 1 🗆 M 2 🗓 F Hours Min (Month, Day, Year) 12/22/1924 87 Yrs. 353-12-5627 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland items 23a or 28a-f sho her must be notified at Director 1 Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6503 GLENWICK COURT 21209 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Armed Forces? offerd Knewn as Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) REAL ESTATE SETTLEMENT CLOSER Be 17 Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **ABRAMS** KROUSE GERTRUDE HENRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W 4528 LAC VUE COURT, FOND DU LAC, WI 54937 ILENE JENSEN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date-UNK. 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 X Removal from State 06/01/2012 ARLINGTON NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) FT. MEYERS, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ INFARCTION MYDCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DAYS FLECTROLYT E IMBALANCE Securitally ist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) DAYS DEHYD RATION that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): attending physician for use as the buria Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Day ☐ Pregnant ☐ Unknown Pregnant at time of death signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be CANCER, PARDXYSMAL SUPRAVENTRICULAR Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? HYPERTHUSION, HYPERLIPEDERMA 24a. Was an has autopsy performed? 1 Yes 2 No page 2 1 Yes 2 No After this certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 IDOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 24 hours after deatle Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a, Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 the only one 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 29c. License number ٥ 006595 MAY-11-2012 10 cause of death (Item 23a) (Type, Print 30. Name and address of Registrar's Signat State 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jean Miller Month 17, 2012 ear 8:17 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Gilchrist Hospice Towson Baltimore County Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral Days (Month, Day, Year) **Jan. 21, 1937** Hours 136-26-9097 Director **75** 1 □ M 2 🕶 F Philadelphia, PA Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at filed within 72 hours efter death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 🗌 Yes 2 🎗 No Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 111 West Road 21204 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Home Maker Own Home permit. Page 1 end 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Todd Goldstein Fav Silver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Melissa Miller-Beatty(Dau.) 804 Stags Head Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Sunday 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Mishkon Israel Cem. 4 ☐ Donation 5 ☐ Other (Specify) May 20, 2012 Baltimore, Maryland Signature of Funeral Service Ucensee Jeffrey L. Gair, Sr. (FSP22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. ZLic.#M00677 2325 York Road Timonium, Maryland 23a. Fort 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Debilly disease or condition resulting in death) Medical Due to (or as a con suruence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 ☐ Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the pasts of examination almost investigation, in this operation, detailed and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Suite 4105 Charle

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mayth Physician/ Day 13 2012°ai 9:55 a. M Paulette A. McNeill Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Bon Secours Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. MD 212-48-0211 64 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21223 128 N. Payson Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Black, White, etc.

African-American Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Self Employed Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anderson Smith Lauretta Doughtery traumatic uge 1 and 2 shc. uspartment of Health and Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4538 Warm Stone Circle, Perry Hall, MD 21128 Betina Fletcher/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5/21/2012 Brooklyn, MD CedarHill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility While Fineral Hone P.A. of Baltimore Co. 21. Signature of Funeral Service Licenses 9200 Liberty Road, Randallstown, MD 21133 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical **Examiner** quentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months? 1 ☐ Yes 2 🗓 No Dav Pregnant at time of death ☐ Pregnam
☐ Unknown 1 ☐ Tes _ ₹ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No page 2 s within 24 hours after death.

To the Funeral Director; After this certificate has 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: ည 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier YHYSICIAN 057543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Sandru MD, 1940 W. Baltimore Street, Baltimore, MD 21223 State

Registrar

MAY 172012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Eleanor McKeithen 4:09 PM Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hospital of Baltimore Baltimme 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 220-28-7498 85 Director 1 🗆 M 2 🕱 F March 9, 1927 North Carolina Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Medical Examiner must be notified at Director 1 XYes 2 No MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5808 Merville Avenue 21215 IISA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 🖾 Never Married 2 🗌 Married 9 þ 1 Yes 2X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural" Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Professor Education 5+ Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ' once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dan Ingram McKeithen Eleanor Herndon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number; City or Town, State, Zip Code) 23185 J. Harold McKeithen - Cousin 5803 Williamsburg Landing Dr., Williamsburg, VA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nelsen Funeral Home 05-12-2012 1 🗆 Burial 2🛣 Cremation 3 🗀 Removal from State . Page Williamsburg, VA 4 ☐ Donation 5 ☐ Other (Specify) & Crematory Metropolitan Funeral Service f Funeral Service Licensee 22. Name and Address of Facility lelle 5517 Vine Street, Alexandria, Virginia 22310 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death > Physician/ neumonia disease or condition Medical resulting in death) (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ retail 0.5 ☐ Pregnant at time of death ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Bipolar Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 🗌 No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a, Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 4 1 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NII SH PATEL MD SINH HOSPITAL OF BALTI MORE 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lee Morgan 2012 10:25 P. ^M Linda 14 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Park Takoma Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 213-56-3344 61 Director 1 🗆 M 2 🗶 F 9/02/1950 Washington, DC 28a-f shov 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ¥ Yes 2 □ No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 728 Richmond Avenue 20910 U. S. A. death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ō Yes 2 No Yes, Give 1 Never Married 2 Married þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. White "natural", Specify: 3 Widowed 4 X Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Telecommunications 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be filed h and Mental H 7 is marked otl Frank Morgan Ellen Colburn Wesley Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Frank M. Morgan/Brother 10 Royal Cove, San Antonio, Texas Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Huntt Crematory 5/17/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 16000 Annapolis Road, Bowie, Maryland 20715 M00544 alla Smito 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Seasontally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Medical Division of Vital Records, P.O. Box 68760 the as attending p IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death the 1 ☐ Yes ∠ ∠ 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 thinknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed Yes 2 certificate 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA this funeral Date of injury (Month, Day, Year) 27. Manner of Death 288 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred After injury 5 Pending Matural of Funeral Director: All letely filled in by the full Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖺 within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)-31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

			For State	State of Maryland / Dep	partment of Health and N Prtificate of Death		2012 15689
			Registrar 1. Decedent's Name (First, Middle, Last)	. •	runcate of Beating	Reg. N 2. Date of Death	3. Time of Death
	Physicia Medic		Barbara Jean			Month D MAY I	b 2012 1:40 AM
	Examin	er	4a. Facility Name (if not institution, give st. SINAI HOSPITAL		4b. City, Town, or Location of Death BALTIMORE	4	c. County of Death
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
	Director		24.44.9346 Usual Residence of Decedent	M 2 XF 66 Yrs.	Widness Bays Thous Will.	03/11/194	" 1
	show dat	tor	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	Mary 28a-f	Director	MD N/	Bat	timore)		1 X Yes 2 □ No
	vith the 23a or st be r		5023 Yellowwob	a Avenue	10f. Zip Code 21209	10g. C	Citizen of What Country?
	items	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
21215-0036	2 hours "natur edical I	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a, Dece	edent's Usual Occupation e kind of work done during most of work	ina	Kind of Business/Industry
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yla	uld be fill I Mental narked o	₽ L	John L. Burgess		Betsy	Carter	
Maryland	2 should be Ith and Men 27 is marke r traumatic	- 7	19a. Informant's Name/Relation ip (Type) Dayelle Marti		ling Address (Street and Number or Rura B Kimble Road B	al Route Number, City o SalHMOre	or Town, State, Zip Code)
ore,	t of Healt If item 2 or other	1	20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b. Place of Disp	position (Name of	Date 20c.	Location - City or Town, State
Baltimore,	t. Page tment o tant: If ijury or		4 Donation 5 Other (Specify)	Druid Pi	age Cemetery 05/2	5/2012/ FR	resville, MD
Bal	permit. Page Department or Important: If any injury or once.		21. Signature of Funeral Service Licenses		2. Name and Address of Tacility Va 8728 Liberty Road	ughn C. Gree L'Pamoalls	tinn MD 21133
			shock, or heart failure. List only one	cations that caused the death. Do not en cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
-	Medical	(F 14	Immediate Cause (Final disease or condition resulting in death)	5EPS.S Due to (or as a consequence of):			Onset and Death
Γ'	Examiner			BI 417RY OBST	RUCTION		2 WKS
	d sit d	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
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09	re be e nysiciar ne buri	lical					
		/Med	IF FEMALE:	c. If yes, outcome of pregnancy			
Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 **No	1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O. B	t the de by the stached	Phys	g 🗌 Unknown	9 Unknown	L Li Comming Death		
ď.	es tha signed d be de		Part II. Other significant conditions con Hypertension	mbuting to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?
ords	requii been should	Completed by				24a. Was an	24b. Were autopsy findings available
Rec	Physician: The law this certificate has ral director, page 2	Somp				autopsy performed? 1 Yes 2	
ta	ician: certifica ector,	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (Chec		
of Vi	g Phys er this c eral dii	e: To	1 Yes 2 Yo 27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 ER/Outpatient 28a. Date of injury 28b. Time	of 28c. Injury at	ome 5 Residence 28d. Describe how inju	6 Other (Specify) HOSPICE
ono	ending eath. or: Afte the fun	ficat	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury	work? M 1 🗌 Yes 2 🗌 No		
Division of Vital Records,	al or Att s after de I Directo	Certificate:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
7	To the Hospital or Attending Physician: The law requires that the ownthing 42 hours after death. To the Funeral Director, After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Examine	ian: To the best of my knowledge, death ir: On the basis of examination and/or inve Practitioner: To the best of my knowledge	estigation, in my opinion, death occurred a	t the time, date and place	ce, and due to the cause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of my knowledg	29c. License number		Date signed (Month, Day, Year)
			> 1catter ac	L MD MHS	RESOOU	ma	2401 W Belvedere
			30. Name and address of person who con	npleted cause of death (Item 23a) (Type,	Print)	RHI TI MARIN	e Bartimore mo 2125
	Sta		31. Date filed (Month, Pay Year) 7 20	32. Registrar's Signature	el al) SULLINUE	
	Registra	ar	11 2 1 ZU	12 32 Hegistrar's Signature	Tarked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death (First, Middle, Last) 3. Time of Death Name (First, 23:29 M Physician/ 05 2012 10 Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battimore (Anter 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min 1 **Ж**М 2 □ F Director 11-27-1949 6 or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 1 Yes 2 No timore 10g. Citizen of What Country? or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. Completed by 1 Never Married Married 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 💓 No Specify and Mental Hygiene. 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+ Be permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked t any injury or other traumatic evence. 19b Mailing Address (Street and 20c. Location Cremation 3 - Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signatu of Funeral Ser rice Lice see Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death should be detached Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. To Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an after death.

Director: After this certificate has autopsy page 2 death? 2 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year, 5 Pending work? 2 🗆 No М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \(\sum \) Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month. Day, Year, 101510

State

Greene Street

e of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Physician/ PM 7332 2017 Helen Maschas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CENTER BAITIMORE University of MARYLAND MEDICA If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 214-24-4365 Months Hours Min. 1 🗆 M 2 🏝 F 83 Director 11-22-1928 West Virginia Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland s 23a or zoon nust be notified a **Funeral Director** 1 Yes 2 K No Parkville Maryland Baltimore 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? USA 21234 8830 Walther Blvd. Apt. 322 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 'n, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced er than "natur , the Medical B Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Title Guarantee Co. Legal Secratary and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Evangelinos John Maschas Aspasia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mrs. Lambryn Stergiou - Niece Wyckoff, New Jersey 07481 460 James Way 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Greek Orthodox Cem. 1 X Burial 2 Cremation 3 Removal from State 05-18-2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 5305 Harford Road Sign turn of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21214 rails Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or read failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Muccordial disease or condition Medical resulting in death) Due to Ar as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as ding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetai ueai ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCOTICEMIC 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an cate has l autopsy performe Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending
Investigation 1 Natural after death Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) filled in by 4 Homicide determined 24 hours a Funeral D

within 24 ho **To the Fune** completely f

State Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of certifier

Brittney

31. Date filed (Month, Day, Year) MAY 17 South Greene St 2. Registrar's Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Williams

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month, Day, Year,

29c. License number

Bait more.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #20b Per FH G927 5/17/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 4 5:24M GOMEZMATEO 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THICOMA PARK MON IGOMERY WASHINGTON MAVENTIST HOSPITA 9. Birthplace (State or Foreign Country Dominican Republic Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 579-76-5752 Hours (Month Day Year) 76 Director 1 XM 2 🗆 F 8-12-1935 Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Hyattsville 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 5805 42nd Avenue 20781 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 ¹X ^{Yes} Dominican republic Specify: Hispanic 3 Widowed 4 Divorced "natural" Completed ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Service Security Officer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic ever once. Ifth and Mental F 27 is marked o r traumatic eve မ Juan Jose Gomez Candelaria Mateo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 42nd Avenue Hyattsville, Md 20781 Hector Mateo 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 5/16/2012 Ardent Crem 4 Donation 5 Other (Specify) Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of FacilityPhillip A Weatherford FS PA 2431 E Oliver Street Baltimore, MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition ANOXIC Physician/ ENCEPHALOPAIHY Medical resulting in death) Examiner ONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year ed by the a Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Loudor 06905 2012 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL AVENUE, TAKOMA PARK. MO MIREDU ADOO, 7600 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

12-03458 George Manning Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State, of Maryland / Department of Haelth and Mental Hygiene

5001g0a	1-For State amend #21 Per FH 5927	te of Death	Reg. No. 2012 1569						
Physician/	Decedent's Name (First, Middle, Last)	Mont							
Medical Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4, 2012 1240 IIIS						
A second	4a. Facility Name (if not institution, give street and number) 4b. City, 16wn, or Location of Death 4c. County or Death 4c. County or Death 4c. County or Death 4c. County or Death								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Bir Foreig Co								
nd how any Ec.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits 1 1 Yes 2 No						
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. teau 27 is marked other than "satural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number	10f. Zip Code 201 21045	10g. Citizen of What Country?						
or death with or items 22 raust be a	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, e No specify:							
hours after natural? Examine ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed) 16b. Decedent grade completed 16b. Decedent grade grad	ecedent's Usual Occupation (Give kind of work don aring most of working life. DO NOT use retired)							
21215-0036 bould be filed within 72 hours at and Mental Hygiene. is marked other than "natural rite event, the Medical Examin TO Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) To Father's Name (First, Middle, Last)	havehouse 18.Mother's Name (First, N	Aiddle Maiden Surname)						
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	George H. Manning	Mailing Address (Street and Number or Rural Ro							
ore, MD Set and 2 should be the straumatic	Evelyn Manning- Hardy 7	OSO Crade Roci	L Way, Columbia HD 120c, Location - City or Town, State						
	4 Donation 5 Other Specify:		Hanover, MD						
Baltimo permit. Page Department of Important: injury or out	21. Signature of Funeral Service Licensee Brian Howell, Sr M01344 per DVR	110220 Gu Hoa 1	ell Funeral Home Rd, Jessup, MD						
Physician /Medical Examiner	Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Immediate Cause (Final disease a.Narcotic and Ethan		tory arrést, shock, or hear Approximate Interval Between Onset and Death						
Saude LACITITION	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):								
760, cate be executed physician and the burial - transit	d.	f,per me,g927 5-30-12 s	m						
760, icate be execuphysician and the burial - tr.	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery						
Sox 687 leath certificath certificath certificate as the for use as the second		Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year						
res that the d res gened by the be detached d by Phy		The same of the sa	e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Uhknown						
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rafter death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach sertification: To Be Completed by P			a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No						
Vital Rec ysician: The I his certificate I director, page o Be Com	25. Was case referred to medical	26.Place of Death (Check only one							
F Vita	Yes 2 No		5 Residence 6 Other: Scene						
ion of tending Pl ceath. tor: After the funeral	1 Natural 5 D n ii (Month, Day, Year)	12:30 pm 1 Yes 2 🕱 No unk	escribe how injury occurred NOWN						
Division o spiral or Attending tours after death. neral Director: Aft filled in by the function.	28e. Place of Injury - At home, farm	m, street, factory, office building, etc. l at Residence 28f. Loc or Apt	cation (Street and Number or Rural Route Number, City Town, State) 6150 Foreland Garth 301 Columbia, MD.						
Division of To the Hospital or Attending Physitin 24 hours after death. To the Funeral Director: After a completely filled in by the funeral Medical Certification: T	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or invaning than programmer stated.	vestigation, in my opinion, death occurred at the tim	ne, date and place, and due to the cause(s)						
	29b. Signature and title of dertifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 5, 2012						
OCME	30. Name and address by person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street, Baltimore, I	MD 21223						
State Registrar		Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15^{Day} Physician/ 05^{Month} 12:03P M 2012 Geraldine McCray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Gilchrist Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X F Months Hours Min Maryland 218-14-0052 0*6904*411928 83 Yrs Director Usual Residence of Decedent 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 XNo MD Baltimore CO. Perry Hall 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 21128 U.S.A. 8619 Lawrence: Hill Rd. items death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I 1 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black 3 X Widowed 4 ☐ Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. 12th Grade College (1-4 or 5+) the N/A Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental has ris marked ot permit. Page 1 and 2 should be fi Department of Health and Mental Important; If item 27 is marked any injury or other traumatic ev မ Edward P. Turner Aretta Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 8619 Lawrence Hill Rd., Perry Hall, MD James McCray(son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) King Mem. Park 05/19/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License Joseph Adress of Brown Jr. Funeral Ho 2140 N. Fulton Ave., Baltimore, Home PA MD21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ be wecks disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or impury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death the P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Was an autopsy performed has page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred Certificate: 5 Pending injury 1 Yes 2 No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

completed

3

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only one

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and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

N. Chones ST rouson MA

2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 5695 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 12, Physician/ Tho ٧. Nguyen 2012 11:15 AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner 7129 Carriage Hill Drive Prince George's Laurel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 217-81-4882 **Director** 1 🕱 M 2 🗆 F 64 6/20/1948 Viet Nam Usual Residence of Deced 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 X Yes 2 No |Maryland| Prince George's Laurel 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral with 7129 Carriage Hill Drive 20707 Viet Nam permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. by "natural", or i 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Asian Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Nonce. Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) V. Nguyen Cuonq Chi Τ. Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7129 Carriage Hill Drive, Laurel, Maryland 20707 Nguyen/Son The ٧u 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, Maryland 5/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Years Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown ed by the at detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has blirector, page 2 s autopsy performed Yes 2 death? 2 X No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 \(\sum \) Yes 2 \(\mathbb{Z} \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident after deat Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier ٌ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5/14/2012 D45880

Registrar

DHMH 17 Rev 06-2011

State

3

and ad

M.D.

Leon Hwang,

31. Date filed (Month, Day, Year)

1396 Piccard Drive Rockville, MD 20850

bress of person who completed cause of death (Item 23a) (Type, Print)

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12-03610		Please	Type or	Print in Blac	k Indelik	ole ink. i	Ensure All Co	pies Are Le	gible.	
Terrence Bruce	Nicl	kerson, Sr. 1- For State	State of	of Maryland / D				l Hygiene	20	12 1569
Dhyaisi	onl	Registrar 1. Decedent's Name (First	Middle Last)		Certificat	te of Dea	tn	2. Date of Dea	Reg. No.	3. Time of Death
Physici Medical Exami		Texrance	. Bru	41	ersor	Sr.		Month May 10, 2	Day Year	2010 hrs
		4a. Facility Name (if not in	stitution, give		<u>e. 00 .</u>		Town, or Location of E		4c. County of D	eath
H'		University Hospit		15 4 4			more			200
Funeral Director		5. Social Security Number	6. Sex	/	n yrs. last birtho	Mon	der 1 Year If Under 2 ths Days Hours		1	Birthplace (State or preign Country)
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* any		10a. State 10b. C	ounty	100	c. City, Town or					10d. Inside City Limits
10re, MD 21215-0036 ages I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If Iften 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once,	tor	MD			Balt	more			10 02/	1 Yes 2 No
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2121 ald be fi Mental 1 marked c event,	Be C	19a Informant's Name/Rel		SOM pe, Print) (W)	£ 110b	Mailing Address	s (Street and Numbe		Vatsun	toto Zio Codo)
2 shour and N	မ	Patricia A	eal A	lickersoi		~ 1/.	re Stree-	1 //	more m	D 21223
l and l Health		20a. Method of Disposition	<u> </u>		20b. Place of I	Disposition (Na y or other place	me of cemetery,	Date	20c. Location - City	or Town, State
			mation 3 ner <i>Specify:</i>	Removal from State	Garri	_	rest 3	5-29-12	Owne	s Mills MD
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum		21. Signature of Faneral S		90		2 Jame an	Address of Facility	eene Fu	neral St	rvices
	7	23a. Part I. Enfet the disea	se or complir	rations that caused the	death Do not (SISC	Balte. Na	+1 Pike		MD ZI 229 Approximate Inter al
Physician Medical	. 1	failure. List only one	cause on each							Between Onset and Death
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Box 6 e death cer the attendi	ysic	1 Yes 2 No 9	Unknown	9 Unknown	e or death 5	Other (Spe	ecify)			
O. Be at the d by the etachec		Part II. Other significant of	onditions c	ontributing to death but	t not resulting in	n the underlyin	g cause given in Part I.			to the cause of death?
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ords, w requir as been s	plet							24a. Was autop	osy prior	autopsy findings available to completion of cause of
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Division of Vital Records, P.O. Box 68760 rat or Attending Physician: The law requires that the death certificate b its after death. **I Director: After this certificate has been signed by the attending physicate by the funeral director, page 2 should be detached for use as the but	8	25. Was case referred to mexaminer?		spital: 1 Inpatient	0 7 5010		26.Place of Death (Ch		D	
ing Physical After this funeral dir	P	1 ✓ Yes 2 No 27. Manner of Death		28a. Date of Injury (Month, Day,Year)	2 V ER/Outp		DOA Other 4 No. 28c. Injury at Work?	ursing Home 5 28d. Describe	how injury occurred	ther:
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ivisiol or Atteneather death Director:	ifica	2 Accident 3 Suicide 6	Investigation Could not be	28e. Place of Injury	- At home, farm	n, street, factor	y, office building, etc.	28f. Location (5 or Town, 5		Rural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide	determined	(Specify)				or rown, s		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal - transi		(Circuit Circy		: To the best of my known the basis of examina						
To the within To the complete	Medical	29b. Signature and title of	a	nd manner stated.			c. License number	-, -10	29d. Date signed (
		Carde	Ha	lldn			O.C.M.E.		May 11, 2012	
-	- 1		-						1	

30. Name and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year).
Registrar MAY 1.7 DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6.50 amu PM Ma 7.012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, **Examiner** or Location of Death 4c. County of Death zaheth Bal UNSING timore Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)
12/09/1916 Social Security Number 6. Sex 7. Age (In yrs, last birthday, If Unde Birthplace (State or Foreign Country) Funeral Months Days 1 M 2 - F Director 218-05-9748 95 Yrs Usual Residence of Deceden show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1121 Armistead Street 21061 II.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 KNo Maryland 21215-0036 hours after 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 7 and Mental Hygiene.
7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 M.T.A Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter M. Namuth, Jr. Lorraine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Mrs. Diane N. Namuth / wife 1121 21061 Armistead Street. Glen Burnie, MD Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State injury or Glen Haven Mem. Park | 05/18/2012 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD any Singleton Funeral & Cremation Services, P.A. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ mran Duell moni on disease or condition resulting in death) Medical s a consequence of): Examiner emen Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of physician and the burial-transit that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) Pregnant at time of death 2 No signed by the a Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed should 110 thy reidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 1 Tyes ျ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral di this Certificate: 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D553 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson 3320 venue State 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 65 Physician/ Day 08 Year 12 MARY 07:10 AM NFELY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE GOOD SAMMRITAN HUSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. (Month, Day, Year) 1 □ M 2**XX**F Director 215-34-8065 Yrs 79 AUG. 20 1932 SOUTH CAROLINA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director r 28a-f sl notified 1 X Yes 2 No MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 112 LARUE SQUARE 21225 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade MACHINE LINE WORKER SPRICE CANS Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental Fishers is marked o မ JOHN B. BROWN BEULAH FEEMSTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is William Neely/Son 1618 Lochwood Rd., Baltimore, Md., 21218 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) injury or Department of Important: If any injury or once. GLEN BURNIE, MARYLAND 4 Donation 5 Other (Specify) CEDAR HILL CEMETERY 05-19-2012 21. Signature of F WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CAREDO PULMONDEY MERES disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** < 24 Hrs + ELECTROLY TO BISTURGANCE SEVENCE AUDEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit + ACUTE KENAL FAILURE >155m 1 SEVERE SER SIG and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HY PERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 🗆 No Yes 2 N 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 No ည No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: death. 24 hours after death Funeral Director:

work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination allow in realignment, many spinor, and the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1001 RAVEN LO0.14

P 25310

BOULEVANIN

29d. Date signed (Month, Day, Year, 05/16/12

BALTIMONE, MD, 21239

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ Month_ 0619 2012 Medical 4a. Facility Name (if not institution, give street **Examiner** 4c. County of Death Himore Baltimore i(a If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 216-36-8005 Director 1 X M 2 🗆 F 72 Nov 24, 1939 Virginia or 28a-f show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director N/A Baltimore Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1254 Carroll Street 21230 USA or items within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 14. Race - American Indian, Armed Forces?
1

X Yes 2 □ No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White If Yes, Give 3 XWidowed 4 ☐ Divorced 1958-62 Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Reproduction Specialist Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file lth and Mental I 27 is marked o ပ Ralph Cecil Petty, Sr. Ethel Belle Stuples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Ralph Cecil Petty, III (Son) 2608 Lehman Street, Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 5/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Fun 1/21 Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. Kevin E Ecker MO0175 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Phytician/ NEVIMONICA Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injur that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death by the a g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) B 101510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore licivus Green State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:05 A-M May Virginia Μ. Parks Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 213-30-4718 1 □ M 2**X** F Director 78 19 1933 May MD Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Pasadena Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 8555 Main Avenue 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Underwriter Insurance Company Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked ပ Vernay Elsie E. Flock James Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JIRGINIA John "Ed" Parks, III If item 27 8555 Main Avenue, Pasadaena, MD 21122 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) May 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 Metro Crematory, Inc. Baltimore, MAryland of Funeral Service Lib nate 22. Name and Address of Facility Signatur Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failule. List only or Approximate Interval Between Immediate Cause (Final Onset and Death Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to him recitate cause. Enter Underlying Cause (Disease or injury Examiner uence of the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🎗 Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Provided in the cause of the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DI ·MD. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25tale of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2355M Physician/ John Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster 8 Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 **X**M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthpiac Country) PA **Funeral** 12/20/1943 207-32-6185 68 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2XXNo Carrol1 Mt. Airy MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21771 4328 Ridge Rd., Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 🔀 No þ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRIPP Contracting 12 Superintendant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Margaret Zupkie Frank Palovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mt. Airy, MD 21771 Susan Palovich/Daughter 105 Hill St., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/14/2012 Winfield, MD Carroll Crematory 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Funeral Home & Crematory, erte 18 1212 W. Old Liberty Rd., Winfield, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death Yes 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 10 26. Place of Death (Check only one) the funeral director, မှ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after death Director: Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per inf g927 5-29-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 03:10AM 2012 PABICH JR May BERNARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Johns Hopkins Bayview Medical Center **Baltimore** Baltimore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 80 Yrs. Date of Birth (Month, Day, Year) **Funeral** Min June 2, 1931 Mary land Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 is marked other than "natural", or thems 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Mary land Examiner must be notified at Baltimore Edgenere 1 Yes 2XXNo Funeral Director 10g. Citizen of What Country? 10e, Street and Number 8026 Dogwood Road 10f. Zip-Code United States 21219 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Merritt Properties 12 years 2 vears Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard J Pabich Sr. Angela P. Dohmer ဂ other traumatic ob. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12210 Lanham Severn Road, Bowie, Maryland 20720 19a. Informant's Name/Relationship (Type. Print) Rebecca Lee Smith Department of Health a Important: If item 27 is any Injury or other trainonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Stanislaus 5/17/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. Scott Gardner 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Preumonio /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No this certificate has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident the within 24 hours after deat To the Funeral Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0070728 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) iov VENKAT PRINDEEP GUNDATLEDD 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Medical 4c. County of Death Examiner 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 **X** M 2 □ F -9permit. Pege 1 end 2 should be filed within 72 hours after death with the Merylend Department of Heelth end Mental Hyglene. Importent: if item 27 is merked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Directo 1 🗆 Yes 2 🕅 No Arrows 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21219 2400 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) IILAElementary/Secondary (0-12) College (1-4 or 5+) ONGS Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ OWSKI Leo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brother 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State MAY 19, 2012 STANIS LAWS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses or complications that caused the death. Do not enter the mode of dying, such as cardiac 23a. Part 1. Enter the shock, or leart Onset and Death Immediate Cause (Final disease or condition NEUMONIA Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospitel or Attending Phyelclen: The lew requires thet the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be deteched for use as the burlei-trensi Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No. 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar shazh

Registrar's Signat

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Iva Vivian Rose 157 M 2012 Medical a. Facility Name (if not institution, give street and number) 4c, County of Death
BALLIMORE **Examiner** 4b. City, Town, or Location of Death Franklin Square Hospital ROSEDAle Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) 220-78-3583 **Director** 1 🗆 M 2 🗶 F 60 July 11,1951 Tennessee Usual Residence of Decedent ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Maryland Dunda1k 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7815 Collingham Drive USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Force Black, White, etc. ö þ ☐ Yes 2 X No 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced al Hygiene. d other than "natural event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Lloyd Wheatly Elsie Cupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Denise Moats / daughter 7841 St. Bridgit Lane Dundalk,Maryland 21222 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Crematory,Inc. 5/17/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fu eral Service Licensee 22. Name and Address of Facility Cremation Society of Maryland, Inc. Stephanie Custer 299 frederick road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nset and Death Physician/ 24 hoors Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury NeumoniA the burial-trar and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 se as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte d be detached for in the past 12 months? Pregnant at time of death 2 No 1 Yes 2 Unknown Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 No 2 1 No Yes To the Hospital or Attending Physician: 3 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ■Natural work? 1 Yes 2 No 5 Pending injury ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) RES 0000 MD 05/15/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-201:

State

31. Date filed (Month, Day, Year, VAY 1 7 2012

32. Registra

Ja. Drive

BALTIMORE, MD 2/237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State State of Maryland / Department / Departmen	artment of Health and M	fental Hy	giene Reg. No. 2	012	1570	15
	Physicia		1. Decedent's Name (First, Middle, Last) James Lee Rogers		2. Date of De Month May	of Death 3. Time			
١	Medic Examin		4a. Facility Name (if not institution, give street and number) Heartland Healthcare Center	4b. City, Town, or Location of Death Adelphi	riu y	4c. Coun	ity of Death	2010 1	
	Funeral Director		5. Social Security Number 5.79-18-0314 Sex 18 M 2 F 7. Age (In yrs. last birthday) 18 M 2 F 91 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da 4 – 1 8	rth av, <i>Year)</i> 3 – 21	9. Birthpl Counti Was	ace (State or Fore y) D. DC	ign
	aryland ta-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Wash	ington			10	d. Inside City Limi	
	with the M 23a or 28 ust be not	Funeral Director	10e. Street and Number 4276- E. Capitol St. NE #101	10f. Zip Code 20019		10g. Citizen o		ry?	
980	2 should be filed within 72 hours after death with the Maryland at and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	b	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Spet If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 ☑ No Specify:	cify Yes or No- Rican, etc.)	В	ace - America lack, White, e	tc.	
Baltimore, Maryland 21215-0036	within 72 hou giene. er than "natu , the Medica'	Completed	(Specify only highest grade completed) (Give life. D	dent's Usual Occupation kind of work done during most of workin O NOT use retired) erground Miner	ng	16b. Kind of	Business Indi	ustry	
yland	ld be filed Mental Hy, larked oth atic event	To Be	17. Father's Name (First, Middle, Last) Daniel A. Rogers	18. Mother's Name Colle	e (First, Middle,		me)		
, Mar	ge 1 and 2 should to tr of Health and Me If item 27 is mark or other traumation		Corine Thoms/Friend 4276	ng Address (Street and Number or Rural - E. Capitol St				0019	1/2
imore	permit. Page 1 a Department of H Important: If ite any injury or ott		To bonar 2 - Oremation o - Tremoval nom otate	matory or other place)	1/12	20c. Location Suitl	and,		
Ball	Departition Depart		21. Sign we of Funeral Service Licensee 22 21. Sign we of Funeral Service Licensee 4. M01149	Name and Address of Facility Hackett's Funer 814- Upshur Str	al Cha	apel, NW DC		11	
	hysician/	00.5	234. Part h. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Chronic Kidne)		or respiratory a	rrest,		Approximate Interval Between Onset and Death	1
	Medical Examiner	<u>ب</u>	resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
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68760	certificate be inding physici use as the bu	Medical	d						
go	death ne atte ed for	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			Date of deliver Month [y Day Year	
	requires that the been signed by the should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the u Hypercholesterolemia	ınderlying cause given in Part I.				cause of death?	wn
Ş,	law e 2	Completed	Atrial Fibrillation				o. Were autop: prior to com death? 1 \(\sum \) Yes \(2	sy findings availab	le of
/ital	Physician: The Taw this certificate has ral director, page 2 s	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	26. Place of Death (Check	only one)			. LI NO	
Division of Vital	nding Phy ath. r: After this ie funeral o	Certificate: T	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28a. Date of injury injury injury			how injury occu			
DIVISI	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funer		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specify)	eet, factory, office	28f. Location (City or Tox	Street and Num vn, State)	ber or Rural F	Route Number,	
:	ne Hospi in 24 hou he Funer ipleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the control of t	stigation, in my opinion, death occurred at	the time, date a	and place, and c	due to the caus	se(s) and manner st	rated.
	with Volume		29b. Signature and title of confifer	29c. License number D260024		29d. Date sign 5/16		ay, Year)	
1	V		30. Name and address of person who completed cause of death (Item 23a) (Type, F Lester M. Miles, M.D. 1160 Var	num St. NE S-30)6 Wa	sh. DC	2001	7	
	Stat Registra		31. Date filed (Month, Day, Year) NAY 1 7 2012 32. Signature	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month obinson 5:20AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Madison Hora 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Director 1 M 2 - F 12 Yrs. Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Fes 2 No TOMORE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 21205 ILSA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 400 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kobinson ည William IODI 19a. Informant's Name/Relationship (Type, Print) 21205 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) i. Page 1 and 2 s' tment of Health a Kobinson -10rita Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 30 L Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death.

The Funeral Director: At pletely filled in by the fu 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tirne, date and place, and due to the cause(s) and manner stated the only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within To the 29b. Signature and 30. Name and ad of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ J'RW 2Č1 :05 AM 00 Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Heat Brookly . + N Th If Under 24 Hrs Birthplace (State or Foreign 6. Sex 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month. Day, Year) 0706 Hours Min Director 1 M 2 M F North (arolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturo" any injury or other traumatic events. 10d Inside City Limits 10b. Count 10c. City, Town or Location 0a. State **Funeral Director** anover, 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 L.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married Black 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CE 1,00 K Be UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ 21076 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Moadow Comes Hanover. 1608 Deer Armstrong Jacque INQ 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 M Burial 2 Cremation 3 Removal from State 5-11-2012 DN HAMPTON Mem Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee OWE elle 20794 OR Koac 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 01 HOOLE disease or condition Medical resulting in death) Due to (o **Examiner** Sequentially list conditions Examiner Due to (or as a consequence of if any, leading to immediate Cause (Disease or injury that initiated events The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 mg Month Dav Pregnant at time of death 5 Other (specify) been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s After this certificate has Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to edica 26. Place of Death eck only one) Certificate: To Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred Natural 5 Pending 2 No Investigation Could not be Accident within 24 hours after deat To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determ Medical 29a Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check Aviation Blvd Glen Burnie MD 21061 29b. Signature and

DHMH 17 Rev 06-2011

State Registrar Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:40 P M Physician/ CUELYN) Kobinson May 2012 Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner N Sinai Hospital of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 214-24-7574 87 Director 1 M 2 🔼 F MARYLAND 1924 October 2 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director BALLIMORE MARYLAND 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Cold Spring 21215 USA Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black White, etc. ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates African AMERICAN 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education HARyland General (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) House Keeper HOSPital other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Julius ACKINS ပ္ Ackins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Cold SPRINGlARE Aline - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, King Memorial Pack May 19, 2012 Woodhwn, Maryland 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Dopation 5 Other (Specify) Service JANCY M. WALLACE FUNERAL 3405 W. Franklin Street funeral 21229 re of Funeral Service Licensee BAltimere HARYland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Colon cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit and Due to (or as a consequence of): The law requires that the death certificate be execu resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ gned by the atter in the past 12 months? Month Year Pregnant at time of death Day 1 ☐ Yes 2 ≥ g ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by renal failure. 2 ANo 3 ☐ Probably 4 ☐ Unknown hypernatremia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 certificate has perform death? 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Cher (Specify nospice 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ after death.

Director: After this funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural Investigation 6 Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

54 1 Execution - works and an overnous day

DHMH 17 Rev 06-2011

31. Date filed (Month, Day State Registrar

(Check

29b, Signature an tile of certifier

Lijun Zhon

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

240

29c. License number

D70334

W Belvedero Ave, Baltimore MD 21215

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Physicia /Medica Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician /Medical Examiner within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of Mar	-		ent of H ate of L		d Mental F	lygiene Reg. No	2012	1570		
n	1. Decedent's Name (First, Middle, Last)	an Elizak	beth S	mith			2. Date of Month Ma y	Death Dav		3. Time of Death 2435 AM		
l r	4a. Facility Name (If not institution, give s Franklin Woods			4b. (Location of D	Death		County of Death			
	5. Social Security Number 6. Sex 214–26–3515 1 □	7. Age ((In yrs. last birt 86	hday) If U Yrs. Mon	nder 1 Year ths Days		Min. (Month,	Day, Year)	Cou	place <i>(State or Foreig</i> ntry) nnsylvani		
5	Usual Residence of Decedent	.	10c. City, Town	or Location	Pike	svill	e			10d. Inside City Limit		
	10e. Street and Number 7527 Slade Av	venue		101	Zip Code	208			tizen of What Cou	ntry? of America		
2	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:			ecedent of H specify Cuba es 2000 No	ispanic Originan, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ameri Black, White Specify: Wh	etc.		
ac completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)		(Give kind of life, DO NO	Usual Occup of work done of OT use retired Erwrite	during most o d)	f working	16b. K	ind of Business/Ir	,		
	17. Father's Name (First, Middle, Last) Homer	Ross Baer					Name (First, Mid aleria Ma					
	19a. Informant's Name/Relationship (Type Bonnie Baer-Green – I		19b. 5	Mailing Add	iress (Street s Lane,	and Number West St	or Rural Route Nu ringfield,	MA 010				
	20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		(Name of or other place ial Pari	7.6-	Date ny 18,2012	18,2012 Baltimore, Maryland						
	21. Signature of Funeral Service License	mah		Evan Evan 8800	e and Addre S Funera Harfon	ss of Eacility al Chape d Road,	el and Crem Parkville,	ation Maryl	Services - and 21234	Parkville		
ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
completed by rhysicial/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									very Day Year		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributions to death but not resulting in the underlying cause given in Part I.									the cause of death?		
Solid Holo	24a. Was an autopsy performed? 1 Yes 2 No 1									topsy findings availa completion of cause of 2 □ No		
	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	25. Was case referred to medical examiner? Charter Company Co										
Columnation:	27. Manner of Death 1											
)	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of iner: On the basis of and manner stat	examination ar	e, death occ nd/or investion	urred at the tigation, in my	ime, date and opinion, deatl	place, and due to h occurred at the t	the cause(ime, date a	(s) and manner as nd place, and due	stated, to the cause(s)		
					29c. Licens	se number		29d. D	ate signed (Monti	h. Dav. Year)		

Registrar DHMH 17 Rev 1/2001

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	larylan					and M	lental Hy	giene		1.0	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7.10
		-	Registrar 1. Decedent's Name (First, Middle, Last))	-	Cer	tificate	OT L	eatn	- 1	2. Date of De	Reg. No	o. 2 []	12	3. Time o	- Dooth
Nog.	Physicia Medic	al	Borin Sam 4a. Facility Name (if not institution, give s	troot and number)			1				May 11,	20		Year	8:30	Рм
	Examin	ier	3901 Palmira Lane	treet and number)					Location of				ontgo			
	Funeral		5. Social Security Number 6. Sex		ge (In yrs. I	ast birthday)	If Under 1		If Under:		8. Date of Birt (Month, Da	th	Jirogo		lace (State	or Foreign
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land	show d at	tor	10a. State 10b. County			y, Town or Loc	cation							1	0d. Inside C	city Limits
Mary	28a-f	Director	Maryland Montgome	ery	Silv	er Spr									1 🗆 Ye	s 2 🕅 No
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21215-0036 within 72 hours after death with the Maryland	tems er mu	Funeral		12. Was Decedent	Ever in U.S		Vas Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No-	USA	14. Race	- America	an Indian,	
36 after d	l", or i		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No		Yes, specif			ı, Puerto F	Rican, etc.)			, White, e	etc.	
-00-	atura ical Ex	letec	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.		16a. Deced						16b K	Specify:	Asia		
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land be filed	nt of Health and Mental Hygiene. If iftem 27 is marked other than "natural", or items 23a or 28a-f show. If iftem 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	70 E	Houl Sam							er's Name I n So	(First, Middle, me	Maiden	Surname)			
Marylai should be	and M is mar aumat		19a. Informant's Name/Relationship (Typ	e, Print)					nd Numbe	r or Rural	Route Numbe					
e, N	Health tem 27 ther tra		Samen Sar/ Wife						_ane	Silv	er Spri					
	ent of h		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			lace of Dispos emetery, crem	natory or oth	er place			ate		ocation - (•		
altir	Department of Important: If it any injury or once.		21. Signature of Funeral Service Licenser		Atla	antic C				/19/ / Fle	ck Fune		n Bur Home		טויו	
m 8.7	를 표 등 등		alle South	M005	44	76	601 Sa	ndy	Spri	ng R	oad Lai	irel	, MD	2070	7	
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final	cations that caused cause on each line	d the death e.	11	/	-			respiratory arr	rest,			Approximation Interval Bet Onset and	tween
N	/sician/ //Medical		disease or condition resulting in death)	ue to cras	a consequ		dar	Ca	10	<u> </u>				-	Onset and	Deall
Ex	aminer	١	Sequentially list conditions,													
g	ısıt	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):								2		
xecute	n and al-tran		that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):								_		
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387 ertifica	ding ph		IF FEMALE:	o livos outcomo	of nun-							1				
Box 68760 death certificate be	attend I for us	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a	2 ☐ Feta	Ideath 3 🔲	Ectopic pre					1	23d. Date Mont			Year
D. He de	by the tached	hysi	9 🗆 Unknown	g 🗌 Unknown												
, P.O.	igned be de	ρ	Part II. Other significant conditions con	tributing to death b	ut not resu	ulting in the ur	nderlying ca	use give	n in Part I.				A.		e cause of d	
ords require	been s	Completed									1 🗆 🗎		-		ably 4 🗌	
e law	e has age 2 s	dwc									24a. Was a autop perfo	rmed?	pr de	ior to con eath?	sy findings and of comments of	avallable cause of
al H	rtificat ctor, pa		25. Was case referred to medical examiner?		_			26. Plac	ce of Death	h (Check	1 \(\text{Yes} \)	2 X N	0 1	☐ Yes	2 ∐ No	
F Vit	this ce al direc	유	1 ☐ Yes 2 No			ER/Outpatient			4 ∟ Nur	rsing Hon	ne 5 🗶 Resid	lence 6	Other	(Specify)		
Division of Vital Records, tal or Attending Physician: The law requires after death.	After 1	cate:	27. Manne of Death 1 Natural 5 Pending	28a. Date of inju (Month, Day	ry /, Year)	28b. Time of injury	28c	. Injury : work?	at ′es 2□:		8d. Describe h	ow injur	y occurred	1		
isio Atten	ector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju					es Z	_	8f. Location (S	treet and	d Number	or Rural I	Route Numb	per,
ital of	ral Dir			building, etc							City or Tow					
Hosp 24 hot	Funer etely fi	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examine	r: On the basis of e	xamination	and/or investi-	gation, in my	opinion/	, death occ	curred at t	he time, date ar	nd place	and due t	to the caus	se(s) and ma	inner stated.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician; The law requires that the death certific within 24 hours after clearh.	To the	_	29b. Signature and title of certifier	Fractitioner: Te th	e best of m	y michledge,		icense i		e and plac			(e) and ma te signed (
			1/2				M	De	35	0.2	33				201	3
	5		30. Name and address of person who cor					2 d	N M	ط ۽ دايا	inator	חר	200	n7		
	Stat	e	Michael Pishvaian 31. Date filed (Month, Day, Year)	, M. D. 38			IT KU	u,	14 • W •	wasi	ing con	, ,,	, 200	07		
	Registra		WAY 1 7 20-		-		.00									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, 20c, perFH, G927, 5/24/2012, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 11, 2012 2:02 Ам Lorna C. Segelhorst Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 1271 Lavall Drive Davidsonville Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min (Month, Day, Year) 486-46-0945 **Director** 1 □ M 2 X F 1937 | Missouri 74 29 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits

1 Yes 2 No must be notified at Director Davidsonville Maryland Anne Arundel o 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1271 Lavall Drive 21035 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: Completed 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Kalthoff Elenora<u>Kappelmann</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Segelhorst Son <u> 1715 Justin Drive Gambrills.</u> MD 21035 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cerretery, cramatory or other place)
Church Cemetery

5/17/2012 Beaufort 4 ☐ Donation 5 ☐ Other (Specify) Beauport. 21. Signature of Funeral Series 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of part line. Immediate Cause (Final Onset and Death Ardiomy Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SB IF FEMALE: use 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Dav 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed?

1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After Natural 5 Pending Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) within To the 29c. License number DD6054 29b. Signature 29d. Date signed (Month, Pay, Year) pleted cause of death (Item 23a) (Type, Print) 6131 Shady Side Rd 20764 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12116 For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rubert Allen Sullivan, Jr. Physician/ Month るいでえ 2012 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 213-40-1045 **XX** M 2 □ F **Director** 69 August 2, 1942 MD 28a-f shov 10b. County 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 XXYes 2 No 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 3345 Paine Street 21211 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. Armed Forces 2 1 ☐ Yes 2 WNo If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. XX Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ementary/Secondary (0-12) College (1-4 or 5+) Highway Maintenance Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rubert A. Sullivan Margaret C. Shuler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sullivan (Sister) 8040 Midhaven Road Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State Lakeview Memorial Park 5/10/12 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto,MD 21211 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death erzure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner encephalogath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of pneumonia and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) jo in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Dinpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 28d. Describe how injury occurred 1 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signatu

Lindy Watanashui

AT 2438946

301 Euniversity Parkway Balkmone MD 21218

May 15,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0955AM 0.5 201 Medical Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death Examiner 4c. County of Death Ka th More Mare 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F Days Hours Min (Month, Day, Year) 02-10-1923 Country) 89 249-48-4834 Director Czech Republic Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County death with the Maryland 10a State 10c. City Town or Location 10d. Inside City Limits Director 1 K Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1651 E. Belvedere Avenue 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces? Black White etc. δ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Structura1 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Engineering 4 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ္ Gustav Schuetz Margaret Schubert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Eha Schuetz - Wife 1651 E. Belvedere Avenue Baltimore, Maryland 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) Hilltop Service Corp. 05-16-2012 4 Donation 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility 21. Signature on Funeral Service Chensee 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one tause/on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown signed by the a 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Yes 2 € page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be Other: 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 5 Pending 1. Natural work' thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of b

Box 68760

P.O.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 12 2012 Z:30A Mac pence Medical give street and number) 4c. County of Death **Examiner** tospice Baltimore Kandallstown 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 245-20-1129 1 №M 2 □ F **Director** or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Nes 2 No Saltimore 10e. Street and Numbe 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral USA should be filed within 72 hours after death with 21208 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. or Yes 2 No 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with. Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic ender. *imployed* l ransporta Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, burt 1516 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Naurial 2 Cremation 3 Removal from State lawn 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature 1 neral Service Lice 22. Name and Address of Facility Howel -uneral Balto Mi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Stage Physician/ End Kenal disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, -transit and that initiated events Due to (or as a consequence of): resulting in death) Last as the burial attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? signed by the atter Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hitei Diseuse 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 🗌 No Yes 2 filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Tother (Specify) Hospital 2 🗹 No Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29d. Date signed (Month, Day, Year) D0053337 5/12/12 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Boulevard Sten-R Chenburne, Md 0934 Aviation 100

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State Registrar 31. Date filed (Month

Year

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 840 PM Physician/ Shuler 10 2612 SPM . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Maryland Medica N/AUniversity If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5, Social Security Number 217-70-1441 **Funeral** Months 1 □ M 2 🔀 F Director 08/06/1958 Maryland 53 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a. State Director iral", or items 23a or 28a-f s Examiner must be notified MD Baltimore Co. Pikesville 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 512 Rocklyn Ave. 21208 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Black "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years of Social Services Case Worker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Mayloy Shuler Ruby Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) it of Health a: If item 27 i Ruby Shuler (mother) 3808 Norfolk Ave., Baltimore, MD 21216 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 XBurial 2 Cremation 3 Removal from State Woodlawn Cem. 05/17/12 4 Donation 5 Other (Specify) Baltimore, MD Signature of Funeral Service Licens 30 seph Adr. of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, 21217 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final - Physician/ Stenosis Horti disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Vear Pregnant 5 Other (specify) Pregnant at time of death signed by the at the detached for 1 Yes 2 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☑ No 1 Yes 2 ☐ No After this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28c. Injury at work?
1 ☐ Yes 2 ☐ No filled in by the funeral 28b. Time of 28d Describe how injury occurred injury 5 Pending s after death. Accident Suicide Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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31. Date filed (Mo

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Baltimore

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			amend #23cPer	Type or Print in PHY G927, 5/29	Black Indelit	ole Ink. Ensure	All Copies	Are Legible	•
		1	For State Registrar	State of Marylan		nt of Health and r te of Death		eg. No. 201	2 15716
Př	nysicia Medic		1. Decedent's Name (First, Middle, Last	Herling			2. Date of Death Month MOV	13 201	3. Time of Death
	xamin		4a. Facility Name (if not institution, give s	neet and number)	4b. Cit	, Town, or Location of Death		4c. County of Dea	ith .
	ineral ector		710 0 ¢ 100 1	x 7. Age (In yrs. I	ast birthday) If Und Months	er 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,	9. Bi Year) 9. Bi	rthplace (State or Foreign ountry)
iryland	ied at	ctor	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location	2.1/	1100 1		10d. Inside City Limits
th the Ma	ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number	20000	10f. Z	ip Code	1	0g. Citizen of What C	ountry?
dea	or items 2 niner mus		11. Marital Status 1 \(\text{Never Married} \) 2 \(\text{Married} \)	12. Was Decedent Ever in U.s Armed Forces?	S. 13. Was Deci	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
15-0036 72 hours after death with the Maryland	al", Exar	eted by	3 Widowed 4 Divorced	If Yes, Give Year or Dates. Arr	ກປ ¹ □ Yes I 16a. Decedent's Us	2 No Specify:	1	Specify: P	s/Industry
1d 21215-0036 iled within 72 hours aftel I Hygiene.	item 27 is marked other than "natur other traumatic event, the Medical	Completed	(Specify only highest gra		(Give kind of w life. DO NOT u POSTO	ork done during most of work	king	US PO	st Office
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Mar 2 shou	27 is ma r trauma		19a, Informant's Name/Relationship (Ty	e, Print) Herling	19b. Mailing Addre	ss (Street and Number or Rui Nampan ox		City or Town, State, Z	N 17
Baltimore, bermit. Page 1 and Department of Heal			20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition (Notemetery, crematory or	ame of		20c. Location - City o	r Town, State
Baltir permit. P Departm	Important: If any injury or once,		21. Signature of F. neral Service Lice is	Done &		and Address of Facility	owe20	Funor	al Horse
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the deat e cause on each line.	th. Do not enter the mo	de of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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executed	an and rial-transit	l Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hypertensi Due to (or as a conseq					20 years
68760 certificate be	attending physician for use as the buria	Nedica		d					
മ്	r the attendin ched for use	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3 🗌 Ectopi			23d. Date of d Month	lelivery Day Year
cords, P.O. law requires that the	been signed by the a should be detached	d by Pł	Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.			to the cause of death? Probably 4 Unknown
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Sion of Vital Attending Physician:	or; Afte the fune	Certificate:	1 📉 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		injury M	work? 1 Yes 2 No			
Division To the Hospital or Attendin within 24 hours after death.	To the Funeral Director; After completely filled In by the funer		4 Homicide determined	building, etc. (Specif	y)	7	City or Town		l.
D ne Hospital n 24 hours	ne Fune pletely fi	Medical	(Check 2 Medical Exami	ician: To the best of my know ner: On the basis of examination e Practitioner: To the best of	on and/or investigation,	n my opinion, death occurred	at the time, date and	d place, and due to the	e cause(s) and manner stated.
To th	To the		29b. Signature and title of certifier	en carp		Pc. License number R118354		9d. Date signed (Mor	
Ì			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, Print)	t Pandina	Mn	21122	
F	Sta legistr		31. Date filed (Month, Day, Year)	32. Filegistrar's Signa	B. bark	t Pasadena	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician/ 1:20 PM 2012 Turner Elizabeth Agnes 05 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Rosed Baltimore Ranklin Square Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) ge (In vrs. last birthday) **Funeral** Months Hours Min 83 1 □ M 2 🖺 F Director 221-16-1981 07-30-1928 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City. Town or Location Director Examiner must be notified 1 🗌 Yes 2 🕱 No Essex |Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code ö 10e. Street and Number 23a Funeral 21221 USA 537 S. Marlyn Avenue permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married TURNER, Elizabeth Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Industry Proof Reader Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Catherine Griffin George Allen Heisterman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jo Ann Wiest - Daughter 505 Poplarwood Court Bel Air, MD 21014 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 05-16-2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lices 5305 Harford Road Leonard J. Ruck, Inc. 21214 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ORU disease or condition resulting in death) Medical **Examiner** diovascular Disease Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No for Day Year Month 4 Pregnant at time of death 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Renal 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has I completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 s performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 5 Pending work 1 Yes 2 No Accident Investigation ∟ Acciden □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 20060560 13/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 617 STEMMERS RUN RD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1 Day 1749 Physician/ 2012^r May M . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Regional Medical Center Anne Arundel Glen Burnie If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Hours 1 □ M 2 🛚 F **Director** Yrs 9-24-1919 Iowa /₁78_1/₁_0308 Usual Residence of De 92 3a or 28a-f show be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No MD Anne Arundel Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a c c must b Funeral 21122 USA 8022 Pine Ridge Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decede... Armed Forces? Yes 2 No 14. Race - American Indian Examiner o. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Caucasian 3 X Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) City of Chicago Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Kate Eldridge Christian Otto Refshauge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8022 Pine Ridge Road, Pasadena, MD 21122 Frank Vitacco/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 5-18-2012 ife Legacy Foundation Tucson, AZ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 21. Si carure of 1 un ral Se is el icense 9200 Liberty Road, Randallstown, MD 21133 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 914EN 5C disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) hed by the attent detached for u in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 400 po 105 is 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?) encotic 24a. Was an page 2 s autopsy has certificate 1 ☐ Yes 2 ☐ No Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deaun.

To the Funeral Director: After this committeely filled in by the funeral di မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 [29b. Signature and title of certifier

Registrar

State

31. Date filed (Morth, Day,

Yol Glas BUTRIC MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

amend27,28a-f,per me,g934 12-6-12 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 21 per fb g927 5-17-12 yt
amend it State Registrar Certificate of Death Reg. No. acedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ma Medical 4a. Facility Name (if not institution, , give street and number) or Location of Death **Examiner** 4c. County of Death HOPKINS The Johns Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) South **Funeral** 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Director** 56 240-44-2414 1 XM 2 - F 11/28/55 Yrs Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be i Funeral 205 N.Rock Glen Road Apt.K 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathaniel Witherspoon Sr. Virginia Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antonio Witherspoon 205 N.Rock Glen Rd.Apt.K Baltimore MD.21229 ant: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Mt.Carmel Cemetery 05/18/12 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Cullen Harris 4210 Belair Road Baltimore, MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Brain norniaho disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Junarachnos Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-tran that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be eath hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No ed by the a g Unknown g Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 🚺 No Completed 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 Yes 2 No pletely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: ည 2 🗌 No 1 ♥/Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred subject fell from stairs when banister failed 5 Pending fd:7:36 pm 1 ☐ Yes 2 X No Accident fd 5-5-12 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Vacant Row House 4 Homicide 28f. Location (Street and Number or Rural Route Num City or Town, State) 605 Biddle St. Baltimore, MD. determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, RES-OUG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA RAHA 170, MI) 1800 N- (Orleans St Baltimore State 7 Registrar

			Please Type or Print in Black Indelible Ink. Ensure A Amend Item 21 per th, g92/,05/17/2012dhb State of Maryland / Department of Health and M State Amend Item 3 per dr.,g927,05/16/2012dhb Certificate of Death	II Copies Ar lental Hygien	e Legible. e	
		1			io. 2012	
	Physicia	n/	1. Decedent's Name (First, Middle, Last) True Caban Mestan	2. Date of Death	ay Year	3. Time of Death 22:55p M
- Marie	Medic Examin	-	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4	c. County of Deat	h
			Southern Maryland Hospital Clinton Man	Jana F	rince	George
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. ✓ Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Co	hplace (State or Feleign untry)
			Usual Residence of Decedent	2-15-19	46 CC	10d. Inside City Limits
	aryland a-f she fied at	Director	10a. State 10b. County 10c. City, Town or Location			1 🗆 Yes 2 🏳 No
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(0	after death with the Maryland II", or items 23a or 28a-f sho xaminer must be notified at		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2 \(\text{Marined} \) Married 12. Was Decedent of Hispanic Origin? (Specific Response) (Sp	Rican, etc.)	14. Race - Ame Black, White	
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pue	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	n Surname)	<i>k</i>
Maryland	ould bad Mer mark mark		. 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rura.	Route Number, City	or Town, State, Zi	.09
Σ.	id 2 sh salth ar n 27 is er trau		Reverly Young P.S. Box 120 E	Vergree	D.N.C	28438
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c.	Location - City or	Town, State
Iţim	nit. Pag artmen ortant: injury		4 Donation 5 Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of the	1-90	race	2310
Ba	Depar Impo any ir	- 49	21. Signature of Funeral Service Licensee C. Douglas, per DVR DVR	ex 1634	Farr	AUT N.C.
			23a. Part 1. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest,	127	Approximate Interval Between Onset and Death
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	git q	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Sequence of Sequenc			
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Box (death ce he attend hed for us	ician	in the past 12 months? 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify)		Month Month	Day Year
О. В	t the d by the	Completed by Physician/Medica	g ☐ Unknown g ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tobacco	o use contribute to	the cause of death?
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ord	v requi	olete		24a. Was an	24b. Were at	utopsy findings available completion of cause of
Rec	The lav ate has page 2	Som		autopsy performed 1 Yes 2	death?	s 2 No
tall	ician: sertifica ector,	Be	25. Was case referred to medical examiner? Hospital: Other: Other:			
of Vi	Attending Physician: The law ir death. sctor: After this certificate has by the funeral director, page 2 by the funeral director, page 2	e: To	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho 27. Manger of Death 28a. Date of injury 28b. Time of 28c. Injury at	me 5 Residence 28d. Describe how inj		cify)
on C	ending eath. or: Afte he fun	ficat	1 → Natural 5 ☐ Pending (Month, Day, Year) injury work? 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. when be runeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Sta		ural Route Number,
Ω	ospital hours uneral	Medical	29a. Certifier (Check (nd due to the cause(s	and manner as s	stated.
	To the H within 24 To the Fl complete	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place 29b. Signature and tities of certifier 29c. License number	ace, and due to the cau	use(s) and manner Date signed (Mont	as stated.
	7 ≥ 1 0 0		1200. Orginados and applications are applications and applications are applications and applications and applications are applications and applications are applications and applications are applications and applications and applications are applications and app	250.1	4-11-1	2
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	d arm.	2 -
			TIMOTHULE HIGHOY 7503 SILLY OHS TO LILLY 31. Date filed (Moth) Pv. Marh 1992 32/Registrar's Signature	iton, III	40/	25
	Sta Registr		31. Date filed (Month Ay, Yar 2012 33 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Thomas We	eddin	-			e of Maryla		Depar	tment o	f Heal	lth and				-egib		0	2	157
Dby	, ai ai c		Registrar 1. Decedent's Name (Firs	Middle I	ast)		Certi	ificate o	Deal	ın		1	2. Date of I	Reg. N	lo.	. 0	3. Time of	of Death
Medical Ex	/sicia kamii		Thomas	, 11114410, 1	Edwar	d	V	veddi:					Month May 13	Day	y Yea	r	1230	
			4a. Facility Name (if not in	stitution,	give street and nur	mber)			4b. City, Baltir	Town, or L	ocation of	Death			4c. County o	f Death		
For	I		Sinai Hospital 5. Social Security Number	. 16	Sex	7. Age (li	n vrs. las	t birthday)		ler 1 Year	If Under	24Hrs.	8. Date o	f Birth (M	M/DD/YYYY	9. Birt	hplace (S	tate or
Fun- Direc		- 1			™ 2 F		34	Yrs	Monti		Hours	Min.	10	22	77	Foreig		MD
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with th	ns 23a be not	L	11. Marital Status		12. Was Dec	edent Eve	er in U.S.						ecify Yes or		14. Race		can Indiar	ı, Black,
death	or iter	Fun	1 Never Married 2		1 Yes	2 X	No		. ,			Pueno r	Rican, etc.)		White		l-	
rs after	niner,	2	3 Widowed 4 15. Decedent's Education		ed If Yes, Give Year or Dates:		oted) [1	1 16a. Deceder		No No		ind of w	ork done	I16h	Specify:			
'2 hour	Exa	eted	Elementary/Secondary		College (1-			during m	ost of wo	rking life.	DO NOT u	ise retire	ed)					
036 /ithin 7	r than	립	9th grade		na]	Disa	bled					Dis		ed	
15-0 filed w Hygie	d othe	ပ္တို	17. Father's Name (First,			Sr							(First, Midd Will:		en Surname) 3			
21215-0036 uld be filed within 7 Mental Hygiene.	mark c even		19a, Informant's Name/Re	homas E. Weddington Sr. Carrie Williams a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zing arrie Williams-Mother 2665 Park Heights Terr, Baltimore									Zip Cod	i) a				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	umati		Carrie Wil	llia	ms-Moth	er						nts ——					۷.	TSTO
ore, s 1 and of Heal	Fife fr		20a. Method of Dispositio 1 December 2 Cree Cree		3 Removal fro	om State		ace of Dispor ematory or of			· I		Date		c. Location -	•		
Baltimore, permit. Pages 1 ar Department of Hee	or of		4 Donation 5 0	ther Spec	lify:		Dri	id R				5/2	1/20	12	Pikes	vil	le,	
Balt permit Depart	ii ji		21. Signature Funeral S	W/	censeo			₩a	KSh w	Address F/H Vabas	West	t ve.	Bal	timo	ore,	Md	212	15
Physic	ian		23a. Part I. Phter the dise failure. List only one	ase, or co	mplications that ca	used the	death. D										Approx	imate Interval
/Med Exami		1	Immediate Cause (Final o	lisease	a. Sharp Force													Death
V).		or condition resulting in death) Due to (or as a consequence of): b.																
		Je.	Sequentially list condition if any, leading to immedia	te	Due to (or as a	consequ	ence of):											
10		Examiner	(Disease or injury that init events resulting in death)	iated	Due to (or as a	consequ	ence of):					_	-				1	
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876	ng phy as the t	N N	IF FEMALE: 23b. Was decedent pregnate past 12 months?	ant in the	23c, If yes, o		of pregna	_	etal death	3	Ectopic	pregnar	псу		23d. Date of Month) ay	Year
Box 68760,	attendi or use	. <u></u>	1 Yes 2 No 9	Unkno	, L	ant at tim	e of deat	th 5 🗌 0	ther (Spe	ecify)				. 10				
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P.O.	signed be det	d b											1 🗌	Yes 2	✓ No 3	Prob	ably 4	Unknown
rds v	should	lete											24a. V	/as an utopsy				ings available of cause of
of Vital Records, ng Physician: The law requir	ate ha	Completed												erformed es 2		leath? ✔ Ye	s	2 No
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ON C ending ath.	he func	ţ	1 Natural 5	Pending	May 13,	Day (Year) 2012		1210 hrs			es 2 🗸 I	lo	Subject a	assault	ed			
Division tal or Attendil	Directo in by t	Certification	2 Accident 3 Suicide 6	Investig Could r	28e Place	of Injury	/ - At hon	ne, farm, stre	et, factor	y, office bu	ilding, etc.			on (Stree		er or Ru	ral Route	Number, City
spital Di	filled	Cer	4 Homicide	determi	(ороспу)								2600 blk F	Park Hei	ights Terra			/ID
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After t completely filled in by the funeral	Medical	(Check only		slcian: To the bes ner: On the basis o	of examin)
To with	COm	Med	29b. Signature and title of	certifier	and manner st	ated.			29	c. License	number			29	d. Date sign	ed (Mo	nth, Day, Y	'ear)
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<i>b</i> /			30. Name and address of							<u> </u>	5 . 142		04000					
ツヾ			Ana Rubio MD.		tant Medical E	xamin gistrar's			imore :	otreet, E	saitimor	e, MD	21223	_		- :		
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			PI6 For State Registrar	Stat			I / Depa		t of H	ealth and N	-		e	1.2	1572	2
	hysicia		Decedent's Name (First, Mid		rl L. W	endler					2. Date of D Month May 15,	eath	- Long Co	ar	3. Time of Death 1:00 A	1
	/Medic Examin		4a. Facility Name (If not institu Long Green Cente		nd number)				Town, or Valtin				o. County of E			
	uneral rector		5. Social Security Number 220–74–4728	6. Sex			st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of E (Month, I October	Sirth Day Year 31,1	9. 959 1	Birthpli Dount	ace (State or Foreig ry)	in
Maryland	f show	tor	Usual Residence of Decedent 10a. State 10b. Cour MD N/A	,			Town or Lo		-	-				10	d. Inside City Limits	
n with the	3a or 28a st be roll	Funeral Director	10e. Street and Number 3113 Keswick Road	1		I		10f. Zip		211		10g. C	itizen of Wha	t Count	ry?	
urs after death	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprimer must be rediffed at once.	þ	11. Marital Status 1 □ Never Married XX N 3 □ Widowed 4 □ Divord	Arm 1 □	s Decedent ned Forces?]Yes 2 (7) es, Give XX ar or Dates:			Was Deced If Yes, spec 1 □ Yes		spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or f o R ican, etc.)	No-	14. Race - Black, V Specify:		tc.	
within 72 hou	r than "natur. I're Medical I	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1) 12th	dent's Education thest grade comple (2)	<i>leted)</i> lege (1-4or 5	5+)	16a. Dece (Give life.	edent's Usua kind of wo DO NOT us	rk done d se retired	ation Juring most of wor Dectrician		16b.	Kind of Busin Contrac		ustry	
vuld be filed Mental Hyc	arked other atic event,	To Be C	17. Father's Name (First, Midd Charles H. Wend							18. Mother's Nan Shirley N	1. Snydei	ſ				
and 2 sho	n 27 Is ma er trauma		19a. Informant's Name/Relati Victoria J. Wen				4245	Elsa 7	Terrac	and Number or Ruce Balto,	MD 212	L1				
Pages 1	ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		I from State	ce		matory or o remator	ther plac Y	5/16	Date 5/2012	Gle	Location - Cit en Burni	e, M	D	
permit.	Import any inj once		John	Atlantic Crematory 5/16/201 Signature of Funeral Service Licenses 5/16/201 Atlantic Crematory 5/16/201 22. Name and Address of Facility Burgee- 3631 Falls Road Balto, MI									itz Fune	ral		
	sician		shock, or heart failure. Immediate Cause (Final disease or condition	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respisionck, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
	edical miner		resulting in death) Sequentially list conditions,	b	Due to (or as											
ou, be executed	sician and burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	Oue to (or as											
UIVISION OF VITAL NECOLOGS, 1.O. BOX 001 for the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.	has been signed by the attending phys e 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	1 Ĺ 4 Ľ	res, outcome Live birth Pregnant a	2 Fetal	death 3	□ Ectopic ¡		у			23d. Date (ery Day Year	
us, r.	signed by d be detac	þ	Part II. Other significant con	ditions contributing	ng to death b	out not resu	Ilting in the	underlying o	ause giv	en in Part I.					ne cause of death?	wn
The law requires t	sate has been page 2 shoul	Completed									24a. W at pe 1 □ Ye	utopsy erformed	2 pri-	or to co ath?	psy findings availab mpletion of cause o 2 □ No	ole of
OI VILAI Physician: T	nis certific director,	Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☑ No	lical Hospita	ıl: 1	ient 2 🗆	ER/Outpati			4 La Nursing	Home 5 □ R	esidence			(y)	
VISION O Attending Pl	or: After to	ation:	Z Accident	nding estigation	a. Date of Inj (Month, Da	ury a <i>y</i> , Year)	28b. Time Injury	of M	28c. Injui Wor 1 🗆	ryat k? Yes 2 □ No			njury occurred			
Lai or Atte	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	4 ☐ Homicide de		e. Place of In building, e						City or	Town, St	ate)		al Route Number,	
ne Hospiř	ne Funera pletely fill	Medical	29a. Certifier 1 Cert (Check only one) 2 Med	ifying Physician: ical Examiner: O ar	: To the best on the basis and manner s	of examina	wledge, dea tion and/or	ath occurred investigatio	at the ti	me, date and place opinion, death occ	ce, and due to curred at the ti	ne, date	and place, ar	id due t	o the cause(s)	
To tl	To tl	M	29b. Signature and title of cer	tifier				T	00	4705.	6	4	Date signed	11	7/	
			30. Name and address of per	on who complete	ed cause of	death (Item	1 (5) (Type	Print)	M	alvose	Avc	BA	Lien	066	2(21)	2
	Sta Registi		31. Date filed (MInthy Day 20)	2 Bener	32. Regist	tr Ps Sign	ark									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15723 For State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Alan Wolfe 12:50 PM May 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8316 Loblolly Lane Pasadena Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 216-30-1560 1**X** M 2 □ F Yrs April 16 1935 77 MD Usual Residence of Dece 10c. City, Town or Location 10d. Inside City Limits Director 28a-f s notified Maryland 1 Yes 2 X No Anne Arundel Pasadena 10e. Street and Numbe 10f. Zip Code r items 23a or iner must be n 5 10g. Citizen of What Country? Funeral 8316 Loblolly Lane 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. "natural", or iten edical Examiner 14. Race - American Indian, Armed Forces?

1 Xes 2 No
If Yes, Give Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 other t US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental F 27 is marked of traumatic even Department of Health and Menta Important: If item 27 is marked any injury or other transconner. 2 Sr. Doris Creamer Robert. Α. Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine A. Wolfe (spouse) 8316 Loblolly Lane, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 1 X Burial 2 Cremation 3 Removal from State 2012 Donation 5 - Other (Specify) Maryland Veterans Cem Crownsville, Maryland Signature of Funeral Service Ligens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Interval Between Onset and Death e cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Discount at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav ☐ Yes 2 L ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 2 40 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physician; The 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be hours after deatl 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a

To the Funeral E

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certif

31 Date filed (Month) Day Year)

COLL

29d. Date signed (Month, Day, Year,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MARIA WATKINS MAY 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Baltimore City 8. Date of Birth (Month, Day, Year) March 29,1943 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🗶 F 69 217-40-4164 Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location must be notified at Director MAryland Baltimore Edgemere 28a-f 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ŏ 21219 23a 7304 Betz Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. , ⊔ Yes 2 No If Yes, Give filed within 72 hours after 1 Never Married 2 Married 21215-0036 ō 1 ☐ Yes 2√☐ No ģ Specify. Specify: 3 Widowed 4 Divorced Year or Dates: other than "natural", rent, the Medical Exa Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Secondary (0-12) 12 years Secretary Sales and Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be Pages 1 and 2 should be Andrew Frederich Oechsler Audrey Kathleen Smith 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Is I Health John Watkins (Husband) 7304 Betz Avenue, Edgemere, Maryland 21219 Item 2 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo Department of Important: If It any Injury or o Oaklawn Cemetery Donation 5 ☐ Other (Specify) 5/18/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Duda-Ruck Funeral Home of Cundalk Inc. 35730 -Scott Gardner 7922 Wise Avenue, Dundalk, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** RESPIRATORY FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** PNEUMONIA PULMONARY EDEMA Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and is the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal death} \) 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, CARCINOMA 2 No 3 Probably 4 Unknown CELL ADRENAL 1 Tyes Completed 24a. Was an autopsy performed? 2 No FIBRILLATION or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 5 Residence Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1000 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

2012

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

MAY 15

4940 Eastern Avenue, Baltimore, MD, 21224

Year

1 ☐ Yes 2√No

Mary land

White

2012

10V

DHMH 17 Rev 1/2001 11595

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MONICA

we and title or certifier

MARWAHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OMC

29c. License number

D0071885

			Please Type or Print in Black Indelible Ink. Ensure			
			State of Maryland / Department of Health and	Mental Hygie	ene 2012	15725
		_]	State Registrar Certificate of Death		g. No.	2. Time of Dooth
	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) Eva Mae Watson	2. Date of Death	Day 2012	3. Time of Death 4, 58 PM
)	Examin	_	4a. Facility Name (if not institution, give street and number) 1124 N. Central Ave Baltimo		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir	s. 8. Date of Birth	9. Birth Cour	place (State or Foreign
	Director		218-28-4641 1 M 2 D4 79Yrs. Montal 55/5 M 2 D4 1	Hug as		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygieine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	10a. State 10b. County 10c. City, Town or Location Path more			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Ma or 28a e notif	I Director	10e. Street and Number	10	g. Citizen of What Cou	ntry?
	th with ms 23a must k	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ameri	
စ္တ	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "natural", or items 25a or 28a-f sho , the Medical Examiner must be notified at	ا۾	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:	erto Rican, etc.)	Black, White,	etc.
-003	atural" cal Exa	eted	3 L Widowed 4 L Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation		6b. Kind of Business Ir	ndustry
21215-0036	hin 72 h ne. than "n ie Medi	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) (Give kind of work done during most of white. DO NOT use retired) FOOD SETVICES	-	Baltimore:	Public School
	filed wit al Hygie d other	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	lame (First, Middle, Ma	aiden Surname)	
Maryland	should be filed within 72 hours aft n and Mental Hygiene. 7 is marked other than "natural", traumatic event, the Medical Exa	욘	Faye Funderbull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Sey M	City or Town, State, Zip	Code)
Mai	d 2 sho alth and 27 is r er traun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 1124 N. Central	Ave, B	altimae,	MD 21202
ore,	ge 1 and it of Hea : If item or other		20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place)	Date 18 2012	Path moz	
Baltimore	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		4 Donation 5 Other (Specify) 21. Signatur Funeral Service (Leaf see 22. Name and Address of Facility)	towell	Funera	e Home
B	permit Depar Impor any in		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	liac or respiratory arres	altimore,	Approximate
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):			
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	executed ian and urial-transit	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):			
0	s be exe ysician e burial	1=				
68760	ath certificate be attending physici for use as the bu	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
Box (e death ce the attend thed for us	by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1		Month	Day Year
P.O.	hat the de ed by the detached	/ Phy	g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	
ds, F	v requires that is been signed be should be deta	ted b				robably 4 Unknown topsy findings available
Division of Vital Records,	has be	Completed		24a. Was ar autops perfor	prior to death?	completion of cause of
al R	sician; The la certificate ha irector, page 2	Be Co	25. Was case referred to medical 26. Place of Death (t	Check only one)	12	
f Vit	Physician; 7 r this certifica ral director, p	은	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursin		ence 6 Other (Spec w injury occurred	sify)
o uo	ending sath. or: After he fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be		and Alexander or Di	umi Pouto Number
ivisi	or Atter de Directo	Certi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	reet and Number or Ru n, State)	rai noote Nambei,
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occured at the time, date and plant (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur			
	Fo the F within 2 Fo the F	Me	29c License number	d place, and due to the	29d. Date signed (Mont	h, Day, Year)
			MI.D. D001178	7	5-14-12	
le			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RWW & Sharker 167 OIN Charles 14. * 410.	5, Balt	imare, M	10 71704
	St Regist	ate	31. Date filed (Month, Day, Year). NAY 1 7 2012 31. Registrar's Signature	,		
	negis	101	1371			

DHMH 17 Rev 7/2009

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Dominic Abell 9:55 P M 2012 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 42825 Lytle Lane Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months 1 X M 2 🗆 F 03/01/1913 99 **Director** 217-36-6543 ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Leonardtown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 42825 Lytle Lane 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Farming Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Edgar Abel1 Emma Pauline Bowles permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic o George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Douglas Abell/Son 42825 Lytle Lane, Leonardtown, MD 20650 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady's Catholic 5/7/2012 Leonardtown, MD of Funeral Service License Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 25 Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury month The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has be lirector, page 2 st autopsy performed? Yes 2 No 1 Yes 2 No Division of Vital the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \quad Residence 6 \subseteq Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 2 🗌 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 📡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my hindwindge, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 62213 12 6 pm 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m p 22650 Cedar Lane Ct., Leonardtown, MD 20650 Patel yresh H. egistrar Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ William 22:54 Anthony Apri 1 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17212 Friends House Road Sandy Spring Montgomery Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Months Min (Month, Day, Year) Country 525-66-6981 **Director** 1 **X** M 2 □ F 79 Mar. 28 1933 New Mexico Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits at Director notified 1 ☐ Yes 2 💆 No MD Montgomery Sandy Spring 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 20860 United States 17212 Friends House Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces?

Yes 2 \sum No Korean Black, White, etc. ρ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Conflict 1 ☐ Yes 2 X No Specify. Specify: 27 is marked other than "natural", traumatic event, the Medical Exar 3 Widowed 4 Divorced **Black** 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72. h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U. S. Government 6 Public Health Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Georgia Collins George Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s it of Health a : If item 27 i 20860 17212 Friends House Road, Sandy Spring, MD Kendall Anthony / Wife 20c. Location - City or Town, State 20a Method of Disposition 20h Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 K Cremation 3 Removal from State 5 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem 4/30/2012 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Muriel H. Barber Funeral Home Box 5038, Lavtonsville, Maryland 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Senile Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Alzheimer's Disease Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Depressive Disorder Exan tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Sacroidosis requires that the death certificate be Box 68760 as the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy ō in the past 12 months? Day Yea Pregnant at time of death 9 Unknown Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autonsy or Attending Physician: The 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 🔀 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pendina 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

101 State only one)

29b. Signature and title of certifier

Kim Kinder,

31. Date filed (Month, Day, Year)

MAY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.P

Registrar DHMH 17 Rev 06-2011 18109 Prince Philip Dr.,

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

#275, Olney, Maryland

29d. Date signed (Month, Day, Year, April 30, 2012

20832

29c. License number

R 18947

3 🛣 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-03471 State of Maryland / Department of Health and Mental Hygiene Benjamin Tillman Brown, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day May 4, 2012 1704 hrs Medical Examiner TILLMAN BROWN, Jr. BENJAMIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Seat Pleasant 6006 Seat Pleasant Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Director JUNE 24,1935 DC 577-46-2433 76 Country 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No or 28a-f show CAPITOL HEIGHTS MD PG permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygicne. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be porfified at occ 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743 US 6006 SEAT PLEASANT AVE Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Specify. BLACK 1 Yes 2 X No specify: 3 Widowed f Yes, Give Yeer 4 Divorced 至 or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired)

Physician

/Medica Examine

To the Hospital or Attending Physiciao: The law requires that the death certificate be executed within 24 hours after death.

To the Fuoeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

Comple	12TH	College (1-4 of 5+)	ENGINEER			GOVERNMEN	Т
PO	17. Father's Name (First, Middle, Las	t)	2102112211	18. Mother's Name ((First, Middle, Ma		
BeC	BENJAMIN BROWN	·		LORRAINE	HARRTS		
8	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre			er, City or Town, State,	Zip Code)
۱ř			3507 SPRINGD				
	MYRA E. HARRIS/CO		Place of Disposition (Name of C			20c. Location - City or 1	
	1 X Burial 2 Cremation 3		rematory or other place)	MAY	15, 2012		July State
	4 Donation 5 Other Specific	- han	YLAND VETERANS			CHELTENHAM	, MD
	21. Signature of Funeral Service Lice	,·	22. Name and Addres			RAL HOMES,	P.A.
	Knik a. Du	vac M01055	5538 MARL	BORO PIKE	, FOREST	CVILLE, MD	20747
	23a Part I Enter the disease or com	plications that caused the death	Do not enter the mode of dving	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
	failure. List only one cause on e	a.complicated by	ve Arneroscier	otic Card	110vascu	lar Disease	Death
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of		res and ACI	are crisik	T THOXICACIO	ц.
	Commercially list and distance by).					
9	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):				
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
×ai	events resulting in death) Last	Due to (or as a consequence of	f):				
#							
Physician/Medical	X UNPENDED	\square AMENDED $23a, 27, 2$	8a-f,per me,g9	29 7-12-1	2 sm		
Ĭ Š	IF FEMALE:	23c. If yes, outcome of pregr	nancy			23d. Date of delivery	
an/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnar	ncy	Month D	ay Year
<u>;</u>	1 Yes 2 No 9 Unknow	Pregnant at time of de	ath 5 Other (Specify)				
ڄ		a Duklowii			22a Did tahi	acco use contribute to t	ho cause of death?
×	Part II. Other significant conditions	contributing to death but not re	esulting in the underlying cause	given in Part I.			
a b						2 No 3 Proba	
Completed by					24a, Was an autopsy		opsy findings available empletion of cause of
면					perform	ed? death?	
ြင္ပ					1 ✓ Yes 2	No 1 ✓ Yes	s 2 No
Be	25. Was case referred to medical examiner?	Hoopital:		ce of Death (Check o			
	1 ✓ Yes 2 No		ER/Outpatient 3 DOA			esidence 6 🗸 Other:	Scene
=	27. Manner of Death	28a. Date of Injury (Month, Day,Year)				w injury occurred	
ţį	1 Natural 5 Pending 2 Accident Investiga	fd 5_/_12	fd 4:50 pm 1	Yes 2 X No	unknown		
liga	2 Accident Investiga 3 Suicide 6 X Could no	280 Place of Injury - At he	ome, farm, street, factory, office	building, etc.	28f. Location (Str	eet and Number or Run	al Route Number, City
Certification: To	4 Homicide determine		ence		Seat Ple	easant,MD.	Pleasant Dr
	29a. Certifier 4 Certifular Physic	clan: To the best of my knowledge					d.
Medical	(Check only one) 2 Medical Examine	er:On the basis of examination a	nd/or investigation, in my opinio	on, death occurred at	t the time, date ar	nd place, and due to the	cause(s)
1 2		and manner stated.		se number		29d. Date signed (Mon	th Day Varal

State Registra

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

May 5, 2012

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 30, Day 2012 Physician/ 12:18 pM Dang C. Bui Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 101-60-1656 **Director** 1 🖾 M 2 🗆 F Sept. 1, 1946 65 Vietnam Usual Residence of Deced 28a-f show 10c. City, Town or Location 10a. State with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 XNo MD Silver Spring Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 321 University Blvd. West, #140 20901 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Medical Examiner Armed Forces? 1 ☐ Yes 2 😾 No Black, White, etc 0 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Asian 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

It if item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4-or 5+) Physician Medical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cu T. Le Tuc K. Bui 2090; 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 University Blvd. West, #140, Silver Spring, MD Hanh K. Bui/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of May Date 6. cemetery, crematory or other place) 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or 2012 Parklawn Memorial Park Rockville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Francis J. Collins 500 University Blvd. Signature of Funeral Service Licenses Funeral Home Inc. W., Silver Spring. Kehard MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypoxic Respiratory Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Hepatic Encephalopathy Sequentially list conditions ir ary, leading to immediate cause. Enter Underlying Exami B Hepatocellular Carcinoma Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) buria attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the at the detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 No Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 X No page 2 death?
1 Yes 2 No 25. Was case referred to medica director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 3 Inpatient 2 ER/Outpatient 3 DOA Certificate: To this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

npletely

Medical

29a. Certifier

(Check

3 29b. Signature and title of certifier

Nabila Khan,

31. Date filed Month, Day, Year,

MD

🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D65305

29d. Date signed (Month, Day, Year) April 30, 2012

29c. License number

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

		-	For State of Ma		artment of Hea <i>tificate of Dea</i>		ental Hygle _{Reg}	0010	1572			
	Diversionis		1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death			
	Physicia Medio	al	Billy G.	Bass	1		April	30 2012	10:28pm			
	Examin	er	4a. Facility Name (if not institution, give street and number) 15115 Interlachen Drive,	#404	4b. City, Town, or Loca	etion of Death Per Spri	na	4c. County of Death	gomery			
	Funeral			e (In yrs. last birthday)	If Under 1 Year If U		8. Date of Birth (Month, Day, Ye	9, Birthpla	ace (State or Foreign			
	Director		244-36-1398 1 № M 2 □ F	81 Yrs.	IVIORUIS Days Fro	Julia Iviili.	01/13/19		Carolina			
	show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		.,,,,,,		d, Inside City Limits			
	Maryla 18a-f tified	Director	Maryland Montgomery		Sil	ver Spr	ing		1 Yes 2 🔀 No			
	a or 2 be no	al Di	10e. Street and Number		10f. Zip Code		10g	g. Citizen of What Countr				
	th with ms 23 must	Funeral	15115 Interlachen Drive, 11 Marital Status 12. Was Decedent E		Was Decedent of Hispan	20906	ifu Vee or No-	U.S				
က	er dea or ite miner	by Fu	1 ☐ Never Married 2 🕱 Married	No 1950-	f Yes, specify Cuban, Me	exican, Puerto R	ican, etc.)	14. Race - America Black, White, et				
003	ırs aft ural", ıl Exal		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1954	1 ☐ Yes 2 🛣 No Sp	ecify:		Specify: Wh	ite			
15-(72 hou n "nat tedica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during O NOT use retired)	g most of working	g 16	b. Kind of Business/Indu	ustry			
712	vithin jiene.		Elementary/Secondary (0-12) College (1-4 or 5	11	Radiation P	hysicis	t	Medi	cal			
pu	filed valued of othe) Be	17. Father's Name (First, Middle, Last)		18.	Mother's Name		rst, Middle, Maiden Surname)				
yla	uld be I Ment narke	7	Nicodemus Bas					Lou Jarvis				
Mai	2 sho Ith and 27 is r traun		19a. Informant's Name/Relationship (Type, Print) Frances A. Bass - Spouse		ng Address (Street and N 5 Interlach							
re,	1 and of Heal item		20a. Method of Disposition	20b. Place of Dispo				c. Location - City or Tow				
imo	Page ment c ant: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parklawn	Mem. Park	05/04	/2012	Rockville,_	Maryland			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	i Funeral H ver Spring,								
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line		er the mode of dying, suc	ch as cardiac or	respiratory arrest,		Approximate Interval Between			
	hysician/ Medical		very liting in dooth)	inson's Di	sease			1	Onset and Death -2 Years			
	Examiner		Due to (or as a	a consequence of);								
	ic	iner	Sequentially list conditions, if any, leading to immediate Due to (or as	a consequence of):								
	scuted at	Examiner	Cause (Disease or injury that initiated events	a consequence of):			_					
_	icate be executed physician at the burial-transfer	edical E	resulting in death, East	2 0011004401100 01)1								
3760	ficate g phys		0									
Box 68	eath certifica attending pl	ian/l		2 Fetal death 3	Ectopic pregnancy			23d, Date of deliver	y Day Year			
Bo	The law requires that the death certificate be executed are thas been signed by the attending physician and page 2 should be detached for use as the burial-traffs.	Physician/M	1 Yes 2 No 9 Unknown	t time of death 5 L	Other (specify)			World				
P.0	that the ned by seta	by Pr	Part II. Other significant conditions contributing to death b	out not resulting in the u	underlying cause given in	Part I.	23e. Did tobac	cco use contribute to the	e cause of death?			
ds,	requires been sign should b						1 🗆 Yes	2 X No 3 Proba	ably 4 Unknown			
cor	law rei nas be e 2 shi	Completed					24a. Was an autopsy performe	prior to con	sy findings available pletion of cause of			
Re	ysician: The law is certificate has director, page 2		25. Was case referred to medical		00 8		1 Yes 2		2 🗆 No			
/ita	siciar s certif	To Be	examiner? Hospital:	ent 2 ER/Outpatie	Othor	Death (Check		be 6 Other (Specify)				
of \	rg Phy ter this neral o		27. Manner of Death 1 X Natural 5 Pending (Month, Da)	ry 28b. Time o			8d. Describe how					
ion	tendir death. tor: Af the fu	Certificate:	2 Accident Investigation		M 1 Tes			- I Alimate	Davida Alumahar			
Division of Vital Records, P.O.	tal or At rs after o al Direct led in by		4 Homicide determined 28e. Place of inju- building, etc	ury - At home, farm, str c. (Specify)	еет, тастогу, опісе		City or Town, S	et and Number or Rural F State)	Houte Nurriper,			
	To the Hospital or Attending Physician: "Thin 24 hours after death and the Funeral Director. After this certification the Funeral Director. After the Completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 🐰 Certifying Physician: To the best of 2 🗋 Medical Examiner: On the basis of e	xamination and/or inves	stigation, in my opinion, de	eath occurred at t	the time, date and p	place, and due to the caus	se(s) and manner stated.			
			29b. Signature and title of certifier	M.	29c. License num		290	d. Date signed (Month, D				
	20+1		30. Name and address of person who complete a cause of d	eath (Item 23a) (Time I		14157		May 01,	2012			
			, , ,		Road, #111,	Rockvi	lle, Mar	yland 20854	4			
	Sta Registr		31. Date filed (Month, Day, Year) 2. Registre	ar's Signature	ونع							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Day ()2 Year 12 Physician/ 01:50 Bean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worce General Hospital Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** -358 Davs Hours Min. (Month, Day, Year) Director 4/12 1928 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director notified 1X Yes 2 No WV Berkeley Martinsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 ıral", or items 23a or Examiner must be ı Funeral 805 Honeysuckle Drive USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Completed white Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) 5 +Homemaker Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Effie D'Aiuto Samuel Reese Pancake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21842 Charles H. Bean, Jr./son 10113 Queens Circle, Ocean City, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Indian Mound Cem. 5/6/2012 Romney, WV 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home Signatu 108 William St., Berlin, MD 21811 10 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician sepsis disease or condition Medical resulting in death) Due (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlyi*n*g cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page 2 s Jas To the Hospital or Attending Physician: The Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **No** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending Investigation 6 Could not be 2 Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my triol/ledge; rad at the time date and clane, and during the naurels and m 29d. Date signed (Month, Day, Year) 29c. License number of death (Item 23a) (Type, Print) General Hospital, 9733 Healthway Drive, Berlin, MD21811 DN 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:15 AM Physician/ Ma Harry Littleton Brittingham Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Regional Prince George Laure If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Numbe **Funeral** Months Days Hours 577548970 Director 1 🛭 M 2 🗆 F 02/10/1941 71 Yrs NJ Usual Residence of Decede 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State with the Maryland Director 1 X Yes 2 No MD Prince George's Laurel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20707 USA 14200 Laurel Park Drive death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Private Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last ဂ္ Ruth Silva Harry Brittingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12703 Purdham Dr. Woodbridge, VA 22192 Wanda Tonic/ Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 5-8-2012 Cemetery 22. Name and Address of Facility BRISCOE-TONIC FUNERAL HOME 21. Signatur if Funeral Service Lice rimberly 12294 Old Washington Rd MD20601 Waldorf 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ meumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Mellitus **Examiner** Diabetes years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami orondry rears burial-trar and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death
Unknown signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniurv 5 Pending Natural Investigation Accident 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my onition, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cherry Pritam S. Saini 9101 Lane 31. Date filed (Month, Day, Year)

State

Registrar

MAY 0 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Rose Marie Badbinton May 8:19A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Country) 212 72 4893 Director 1 M 2 X F 61 03/30/1951 Yrs. MD show. 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f MD Calvert North Beach 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō er than "natural", or items 23a of the Medical Examiner must be Funeral 3914 7th Street 20714 USA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 ☐XNo by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Dept. Of Treasure Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Butler Alice Kane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roshannda Williams/Daughter 7995 Soloman's Island Rd. Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date XBurial 2 Cremation 3 Removal from State Charles Mem. Cem. 5/9/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 2294 Old Washington Rd. Waldorf, 20601 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Other (specify) 4 Pregnant a Pregnant at time of death been signed by the a should be detached 1 ☐ Yes ≥ L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperkalemia 2 No 3 Probably 4 XUnknown 1 Yes Completed Renal Failure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 perform this certificate Yes 2X No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: ၉ 1 X Yes 2 🗌 No 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 5 Pending ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [3 [only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year, 05/01/2012 D0064100

Registrar

Bhikkasi, S. M.D. 1500 Forest Glen Road Silver Spring, 31. Date filed (Month, Day, Year) MAY 0 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

103 - 4 5 - 19 5 0 12 12 12 13 14 15 15 15 15 15 15 15			1- For State Registrar		Certificate of	f Death			Reg. N	o.	012	157:
Southern Maryland Hospital Control Contro			1. Decedent's Name (First, Middle, La Jarron Alexa	nder Byrd				Month	Day	y Year		
103-45-1950 126 12			The second secon			-	ocation of De	ath				
The State of the County of the	Funeral Director		103-45-1950		.,						Foreign	
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O.C.M.E. May 6, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit	Sertification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last WUNPENDED IF FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigal 3 Suicide 6 Could no determine	Due to (or as a consequent) AMENDED 23a, 27 23c. If yes, outcome of particular of the pregnant at time of the	lained De loce of): loce o	ath In In er me, g929 al death 3 ner (Specify) 26.Place of	Death (Checker'4 Nurat Work?	CSUDI) -12 sm 23e. D 1	d tobacco Yes 2 [as an itopsy arformed? ss 2] Residue how in	3d. Date of do Month o use contribution in the principle of the principle	Be B	Year Year Juse of death? Unknown findings available ation of cause of No
Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	but a death. The law factor of Affecting and the law requires that the death certificate be executed the hours after death. The law factor. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit to the law factor is the law factor in the law factor in the law factor is a standard factor in the law factor in the law factor in the law factor is a standard factor in the law factor in the	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine (Check only 1 Certifying Physic one) 2 Medical Examiner) 2 Medical Examine	Due to (or as a consequent) AMENDED 23a, 27 23c. If yes, outcome of particular of the pregnant at time of the pregnant at time of the particular of the parti	lained De loce of): loce o	ath In In er me, g929 al death 3 ner (Specify) 26.Place of 3 DOA or or 1 Yes et , factory, office build red at the time, date on, in my opinion, do	Ectopic present in Part I. Death (Checker's North Work? 12 X No ding, etc. and place, a eath occurre	anancy 23e. D 1	d tobacci Yes 2 as an atopsy arformed? as 2 Resid be how in In (Street 1, State) On, Mi ause(s) a	3d. Date of do Month o use contribution of the print of	elivery Day te to the ca Probably are autopsy or to compleath? Yes Other:	Year Year 4 V Unknown findings available etion of cause of 2 No
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7° 2012 2012 May Edna Braden Frances 10:54 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 47762 Wickshire Drive Lexington Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 279-46-7619 65 1 □ M 2 🗓 F April 16,1947 West Virginia Usual Residence of Decedent or 28a-f show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 72 hours after death with 47762 Wickshire Drive 20653 United States "natural", or items edical Examiner mu 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian. Armed Forces?
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 12 Communications Supervisor U.S. Government is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Violet Bonk Hartzell Jones, Sr. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath an Important: If item 27 is any injury or other trau Howard E. Braden, Jr./ Spouse Lexington Park, MD 20653 47762 Wickshire Dr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 XCremation 3 Removal from State Brinsfield-Echols Cre. 05/08/12 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD o Fun ya Sirvia Lica de 22. Name and Address of Facility 22955 Hollywood Road Margaret H. Hicks, M01613 Brinsfield Funeral Home, P.A. Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 2 Years Immediate Cause (Final Physician/ Motostotic adeno cercinous disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? Day Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ! 1 ☐ Yes 2 ☐ No Yes 2X No ours after death.

eral Director; After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending Accident work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ceftifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 68846 MI 2012 who completed cause of death (Item 23a) (Type, Print)

Registrar

30. Name and address of person

Dr. Amir Khan, M.D.

25500 Point Lookout Road

Registrar's Signatu

20650

Leonardtown, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Month May 2:23 1, ΑM Bonny Marie Bassford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL **EDGEWATER** 406 BAYVIEW DR | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAY 6, 1960 9. Birthplace (State or Foreign Country) MD Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔀 F 51 **Director** 219-78-4836 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 No MD ANNE ARUNDEL **EDGEWATER** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 406 BAYVIEW DR 21037 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black. White, etc Armed Force þ 1 X Never Married 2 Married Yes 2 No Specify: WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) N/A DISABLED 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 GLADYS PAULINE BAILEY WILBUR RALPH IRVING BASSFORD, SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) EDGEWATER, MD 21037 RALPH I. BASSFORD/ BROTHER 406 BAYVIEW DR., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) KALAS CREMATORY 5/7/2012 EDGEWATER, MD 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 21. Signature Funeral Service Licens 2973 SOLOMONS ISLAND RD., EDGEWATER, Las a daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ach line. 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between nset and Death Immediate Cause (Final Pnysician/ & months norexio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 🔀 No Day Month Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 X No 1 🗌 Yes 2 📝 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 Tes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural iniury Accident 5 Pending Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical K certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Day, Year) D0040901 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis NANCY DRIVERA ING, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland	/ Department of H Certificate of D	Health and N			2 15738
			Registrar 1. Decedent's Name (First, Middle, Last)	Oct timeate of E	Jean	2. Date of Death	g. No.	3. Time of Death
	Physicia Medio		Elza M. Baird			April 25	5, ^{Day} 2012 Year	10:53 p м
	Examin		4a. Facility Name (if not institution, give street and number) 13906 Old Chapel Road	4b. City, Town, or Bow	Location of Death		4c. County of Dear Prince G	
~	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last I.	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign untry)
6	Director		577-32-6205 1 M 2 X F 84	Yrs.	TIOUIS WIIII.	Jun. 29,		Maryland
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	th with ms 23 must	Funeral Director	13906 Old Chapel Road	207			U.S.A.	
10	er dea or itel niner		11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
030	rs afte iral", Exan	ed b	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		l	19b. Mailing Address (Street a				Code)
	and 2 Health em 27 ther t			13906 Old Cha				
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot			e or Disposition (Name or Eterants y Ceimette Eltenham	fry 5-1-1		Oc. Location - City or	
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ä	any Deg	1	mahure Media	6512 NW Cr				0715
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	ledical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and	d/or investigation, in my opinior	 death occurred at 	the time, date and	place, and due to the o	ause(s) and manner stated
	o the	≥	only one) 3 Certifying Nurse Practitioner: To the best of my kn 29b. Signature and title of certifier	nowledge, death occurred at the 29c. License	ne time, date and pla	ce, and due to the	cause(s) and manner as	s stated.
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	3.	-	30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)	15 / 0	42.200	11-412	
	W		30. Name and address of person who completed cause of death (Item 23a STVAVT E. SE ON CV, WO 33. Date filed (Month, Day, Year) 32. Pegistrar's Signature	LUOS Mea	ical Pal	nuway,	Hunapol	is, ma.
	State Registra		31. Date filed (Month, Day, Year) MAY 0 2 2012 32. Registrar's Signature	back				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Walter Harvey Beardmore 4:40AM 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arnold Future Care Chesapeake Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 86 220-16-7862 1925 Maryland July 29, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show or than "natural", or items 23a or 28a-f shov the Medical Ever, ingr. ust be netflied at 1 ☐ Yes 2, ☐ No Maryland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 1620 Ridout Road 21409 U.S.A. Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ★XXYes 2 ☐ No 11. Marital Status 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 □Yes XXNo White Yes Give Specify: þ Year or Dates: 1943-46 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trailmath. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Circuit Court Judge Judicial System 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Beardmore Drucilla Cassell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elsie Beardmore/wife 1620 Ridout Road Annapolis, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 5/3/2012 St. Margaret's Cem. Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Juneral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Parkinson ndstage disease or condition resulting in death) /Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) P.O. I detached 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate I 1 ☐Yes 2 No 2 🗌 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Manner of Death 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 31. Date filed (Month, Day, Year) NAY 0 1 2012

-04

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

866) Veteras Hwy Millersville 32. Aegistra's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 | 2 For State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sandra Banks Tawes 11:07A M 2012 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Wilcomi DILC at 0 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 219-46-4633 1 □ M 2 🛚 F Months Hours 64 Director Maryland Usual Residence of Decedent show ms 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Virginia Suffolk Suffolk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 Wood Duck Court 23434 IISA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò ò 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 XWidowed 4 ☐ Divorced White Completed nt of Health and Mental Hygiene.

If item 27 is marked other than "natu or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyy Important: If item 27 is marked oth any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lawrence W. Tawes Ada Frances Riggin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Baines/Daughter 307 Wood Duck Court, Suffolk, VA 23434 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 4/27/2012 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21904 21. Signature of Funeral Servi Keiten Snow Hill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2/ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an autopsy certificate Yes 72 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHUIAM 1500 us 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:00 AM JOHN DANIEL BRERETON APRIL 2012 Medical 28 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 303 EAST CAMPUS AVENUE CHESTERTOWN **KENT Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days 02/01/1922 90 Yrs **Director** 089-16-8113 NEW YORK Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director notified 28a-f 1X Yes 2 □ No MD KENT CHESTERTOWN 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 303 EAST CAMPUS AVENUE 21620 UNITED STATES tems Was Decedent Ever in U.S. Armed Forces?
1

X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 X Married filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates. 1944-45 WHITE Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than College (1-4 or 5+) Elementary/Seconday (0-12) the 12 5+ REGISTRAR **EDUCATION** event, Be 17. Father's Name (First, Middle, Last) t of Health and Mental Health and Mental Health and Trismarked oth or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be FRANCES RADIGA RICHARD BRERETON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY BRERETON / WIFE 303 EAST CAMPUS AVENUE CHESTERTOWN, MARYLAND 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State <u>÷</u> ፟ δ Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 04/30/2012 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. SPEÉR ROAD CHESTERTOWN, MARYLAND Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 the use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ ō in the past 12 months? Pregnant at time of death Month Day Year ned by the a e detached f Yes 2 No signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. contribute to the cause of death? 23e. Did tobacco use ρ Division of Vital Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 2 No ☐ Yes 25. Was case referred to yedical funeral director, Be 26. Place of Death (Check only one) examiner? ၉ 2 🗌 🌠 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. May er of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending Natural work? 2 🗌 No Investigation Accident filled in by the 6 🗆 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 Certifying Nur Signature and title of certi 29d. Date signed (Month, Day, Year) 15 completed cause of death (Item 23a) (Type, Print) and address of person who + 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY

Registrar

BEAWBRUN, LUCILLE

			Please Type or Print in Black State of Maryland / Dep		-	_		
		1	_ POI	ertificate of Death		Reg. No. 2012	15742	
ľ	Physicia		1. Decedent's Name (First, Middle, Last) Lucile Therese Beaubrun		2, Date of Dea	Day Year	3. Time of Death	
68	Medic Examin		4a. Facility Name (if not institution, give street and number) Doctors Community Hospital	4b. City, Town, or Location of Death Lanham	17 11-19	4c. County of Death Prince Geor	ge's	
	Funeral Director		5. Social Security Number 214-06-9351 Usual Residence of Decedent $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bird (Month, Da Oct.31	y, Year) Country)	e (State or Foreign	
	aryland a-f show fied at	ector	10a. State 10b. County 10c. City, Town or L Maryland Prince George's Beltsvil.		1	10d.	Inside City Limits	
	with the M 23a or 28 ist be not	Funeral Director	10e. Street and Number 11510 Montgomery Court	10f, Zip Code 20705		10g. Citizen of What Country Haiti	?	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Black, White, etc. Specify: Black		
21215-0036	within 72 houn giene. ier than "natu ; the Medical	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) S tress	iing	16b. Kind of Business/Indus	try	
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, Maryland	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Betto Alan Beaubrun -son 1151	iling Address (Street and Number or Rui O Montgomery Court	Beltsv			
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 9ther (Specify)	20c. Location - City or Town, State SilverSpring, Maryla				
Balt	permit. Depart Import any inj			Bonald W. Borgward 4400 Powder Mill R			-	
Ĉ	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshow, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Arten Dis		In	oproximate terval Between nset and Death	
	e executed cian and ourial-transit	al Examiner	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (urfat a consequence of): c. Due to (or as a consequence of):					
. Box 68760	nat the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown d	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Da	ay Year	
s, P.O.	v requires that the been signed by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		obacco use contribute to the o		
Records,	The lav ate has page 2	Completed			1 Yes		letion of cause of	
f Vital	Phy:	: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of injury 28b. Time	of 28c, Injury at	ome 5 🗆 Resi	dence 6 Other (Specify)		
Division of	the Hospital or Attending In the 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Certificate:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined (Month, Day, Year) injury 28e. Place of Injury - At home, farm, s building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Street and Number or Rural Ro vn, State)	oute Number,	
Ó	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat (Check 2 Medical Examiner: On the basis of examination and/or inv	estigation, in my opinion, death occurred	at the time, date a	and place, and due to the cause		
	To the within 2 To the comple	W	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of partition	29c. License number D 70/0 Z	lace, and due to	29d. Date signed (Month, Da)	/, Year)	
	イン		30. Name and address of person yno completed cause of death (Item 23a) (Type IVAN ZAMA M.D. 8118 Good L		AM, MA			
ľ	Sta Registr		31 Pate filed (Manth, Day, Year) 32. Registrar's Signature					

12-03605 Clayton Thoma	s Bri	unner St	pe or Print i ate of Maryla	and / Depa	artment of	Health a				.egibl	e. 2 (71	2 15	71
Physici	an/	1- For State Registrar 1. Decedent's Name (First, Midd	le.Last)	Ce	ertificate of	Death		I	2. Date of D	Reg. No			3. Time of Death	1 -
Medical Exam		•							Month May 10,	Day	Year		1715 hrs	
		4a. Facility Name (if not institution 10708 Oak Forest Dri	· -	umber)	4	tb. City, Town, Hagersto		on of Death	_		c. County o			
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		nder 24Hrs.	8. Date of				place (State or	
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A		Usual Residence of Decedent												
nw any		10a. State 10b. County Maryland Wash	ington		, Town or Locati Hagerst								10d. Inside City L	
uyland Sa-f sh	ctor	10e. Street and Number				10f. Zip Code	9			10g, Cit	izen of Wha	at Count		
the Mar 24	Director	10708 Oak For	est Drive				740				USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a ar 28a-f shaw injury ar atther traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status		cedent Ever in U		s Decedent of es, specify Cub				No-	14. Race - White,		an Indian, Black,	
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ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be C	Carl Edward B	*					rol Sh		e, Maider	i Surname)			
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury ar nither traumati		Carol Brunner 20a. Method of Disposition	- mother	1206	10708 Place of Disposi	Oak Fo		Drive	, Hag	<u> </u>	OWn,			
Baltimore, permit. Pages I an Department of Hea impurtant: If ite		1 Burial 2 X Cremation	3 Removal fr	om State	crematory or oth	er place)	•	- /11		ļ		-		_ 1
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Ba Perm Depz Imp		SCAR	MM	nuces		5 E. Wi		1111					21740	
Physician		23a. Part I. Enter the disease, or failure. List only one cause		aused the death	. Do not enter th	e mode of dyir	ng, such a	s cardiac or	respiratory	arrest, sh	ock, or hear	t	Approximate Inte	
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Box 68760, e death certificate be the attending physical for use as the but	Physician/Medica	23b. Was decedent pregnant in the past 12 months?	e 1 Live b	irth	2 Fet	al death 3	BEcto	pic pregnan	су	23	d. Date of d Month	Da	y Year	
Sox 687 leath certific e attending for use as t	ysici	1 Yes 2 No 9 Unk	nown 9 Unknown	ant at time of de own	eath 5 Oth	er (Specify)				- 1				
that the d ted by the detached		Part II, Other significant conditi			esulting in the ur	nderlying cause	e given in	Part I.	23e. Dio	tobacco	use contrib	ute to th	e cause of death?	>
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Division of Vital Records, no Attending Physician: The law requir is after death. a) Director: After this certificate has been sited in by the funeral director, page 2 should be a page 2.	å	25. Was case referred to medical examiner?	Hospital:	npatient 2	ER/Outpatient		Other	th (Check or		Pacido	ence 6	Othor	Propo	
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Division of Vital Records, P.O. Box 68760, Ta the Hospital or Attending Physician: The law requires that the death certificate be execution after death. To the Funeral Director: After this certificate has been signed by the attending physician at completely filled in by the funeral director, page 2 should be detached for use as the burial - to	Medical	one) 2 Medical Exam		of examination a										
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		 Name and address of person Carol Allan, MD Ass 	who completed caus sistant Medical	•	,	more Stree	t, Baltin	nore, MD	21223					
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Regist	rar	MAY 1 7 2012	Maria.	A Mac	Mas									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 05 09 2012 5:05 Ronald Leon Broadwater /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 22 Uhl Street Frostburg Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 □ F 84 28 1927 212-24-1232 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD Allegany Frostburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 23a 22 Uhl Street 21532 U.S.A. Funeral items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status orces? 1945 Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Celanese Corp. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Manley Broadwater Eva Rosenberger Broadwater ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16726 Virginia Ave Williamsport MD 21795 Department of Health a Important: if item 27 is any injury or other tra <u>Manley Lind Broadwater son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 05-14-2012 Frostburg Mem Park Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. Mcas47 60 W. Main St., Livers. Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** one year Due to (or se a consequence of) Canco disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □No cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

3altimore, Maryland 21215-0036

1 Natural
2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 10, 2012 Moniocks 23a) (Type, Print)
Walsh Rd Cumberland MD 2/502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JoAnn Christian 1649 рМ 04 12012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Prince Ge Cheverly Cente George 8. Date of Birth (Month, Day, Year) tate or Foreign **Funeral** Months Hours Min. Country) 579-64-7540 1 🗆 M 2 😾 F Director 62 D.C. 08/22/49 Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County death with the Maryland 10a State Director DC Y Yes 2 □ No Washington 10e Street and Number 10f Zin Code 10g. Citizen of What Country? ō ms 23a or Funeral 5054 8th Street NE 20017 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. . o. ò 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working the Me life. DO NOT use retired) Ith and Mental Hygiene.
27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Secretary 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္စ Thomas Thompson Annie Ingraham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 siment of Health a Luther T. Christian Hubsand 27 Important; If item 27 any injury or other to once. 5054 8th St NE Washington, DC 20017 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Department of ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln 05/05/12 Brentwood, Md 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Snead Funeral 5732 Georgia Home & Cremation Ave NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): buri physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the Se IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery for in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Tunknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autons certificate has performed? Yes 2 No page death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗹 No 1 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manger of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be within 24 hours after de
To the Funeral Directo 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature aAd title of certif 29d. Date signed (Month, Day, Year) 3688 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital DR Cheverly, Md 20785 Griffin Davis, M.D. 31. Date filed (Month, Day, Year) State Registrar

amend #23a, Pt. I,23a-f,per me,g928 6-8-12 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G927 5/31/2012 JH

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	/land f show ed at	호	10a. State 10b. County		10c. City, Town or	Location					10	d. Inside City Limits
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If Yes, speci	fy Cuban	n, Mexican, Pue	erto Rican, etc.)		ce - Americar ack, White, etc	c.
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Š	d 2 sh alth ar 27 is		Kathleen Bellinger/Mother 25065 Gallant Man Drive, Hollywood, MD									636
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Juanita Jane Cathell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 15 bury Wicomico If Under 1 Year If Under 24 Irs 8. Date of Birth Funeral . Age (In yrs. last birthday, 1 M 2 X F Months 12/20/1920 Maryland 197-07-3558 Director 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Worcester Eden 1 Yes 2 X No 10f. Zip Code 21822 o 10e. Street and Number 10g. Citizen of What Country? must be Funeral 23a 3510 Yacht Club Rd USA "natural", or item ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Wildowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Race Track 10 Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lillian Bounds Willie Bounds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3510 Yacht Club Rd., Eden, MD 21822 Dawn C. Brown/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place
Wicomico Memorial 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specifientombment 5/3/2012 Salisbury, MD . Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCV disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or limital that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month ☐ Ectopic pregnancy ☐ Other (specify) signed by the atte Month Day Year Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perfo 1 Yes No. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 20 Certificate: 27. Manger of Death 10/10 28b. Time of 28c. Injury at Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Fractioner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Fractioner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Fractioner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Fractioner to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Fractioner to the basis of examination and/or investigation, in my opinion, death occurred at the time. (Check 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) D 63199 4/29/12, Name and address of person who completed cause of death (Item 23a) (Type, Print)
OGES H VOHICA 910 EASTERN SHORE DR., SAUSBURY, MD, 31. Date filed (Month, Day, State 32 egistrar's Signature 2012 Registrar

		•	State Registrar			Ce	rtificat	e of E	Death			Reg. No	20	12	13	143
	Physicia	an/	1. Decedent's Name (First, Middle, La	,	,						Date of Dea		v	Year	3. Time of	
	Medic	al	4a. Facility Name (if not institution, give	David Dr	lazın		I	_			Pril	23		072	1600	M
	Examin	er	Suburban H	· ·			4b. City,	Town, or	Location of D Bethe			4c.	. County o		gomery	,
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. las	st birthday)	If Under	1 Year Days	If Under 24		Date of Birt Month, Day	th v. Year)		9. Birthpl	ace (State or	Foreign
	Director		577-52-8614 Usual Residence of Decedent	X M 2 □ F	74	Yrs.		,			rch 0		938		ington	, DC
	land f show d at	tor	10a. State 10b. County		10c. City,	Town or Lo	cation			,				10	d. Inside Cit	,
	Mary 28a-1 notifie	irec	Maryland Montg	omery					Chevy C	hase					1 🗌 Yes	2 🐧 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 4601 N. Park				10f. Zip		20813				tizen of WI	u.s		
99	fter deat ", or iten aminer	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Endemoder Forces? 1 X Yes 2 1 f Yes, Give	No 196	4-	Was Deced If Yes, sped 1 ☐ Yes		spanic Origin? n, Mexican, Pu	(Specify Yuerto Ricar	es or No- n, etc.)	- 1		, White, e	c.	
ö	atural	eted	3 Widowed 4 X Divorced 15. Decedent's B	Year or Dates.	196	5	dent's Usua						Specify: ind of Bus		hite_	
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2	d with lygien ther th	Be C		4				Own						ox C	ompany	
Maryland 21215-0036	d be file fental H irked oi tic ever	70 B	17. Father's Name (First, Middle, Last) Alexander Drazin 18. Mother's Name (First, Middle, Maiden Surname) Edith Harrison							n						
lar.	should and N is ma	10	1				-					per, City or Town, State, Zip Code)				
	and 2 Health em 27 ther tr		Heather Udell - 20a. Method of Disposition	Daughter	20h Ble	5224			Drive,		kvill					
Collego Baltimore.	Page 1 Iment of 1 tant: If it jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control Contro		ce	metery, crei 2an Me	matory`or o 2m. Go	ther plac Videv	is 05	Date 5 / 01 / 2		Ol		Mari	land	
6) Ball	permit Depar Impor any in		21. Signature of Funeral Service Licen	mell r	1010				ss of Facility Hamps hi							
PPUZ	Physician/		23a. Part 1. Enter the disease or com shock, or heart failure. List only of Immediate Cause (Final	plications that caused one cause on each line.	the death.	Do not ent	er the mod	e of dying	g, such as card	diac or resp	piratory arr	rest,			Approximate Interval Betw Diseased D	veen
3	Medical Examiner		disease or condition resulting in death) a. Due to (or as consequence of):													
7	Examiner	e.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury							au	71					
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H.	cate be executed physician and the burial-transit	al Ex	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):		•								
99	ate be	Medical		d												
4 1/1	<u>≔</u>		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			7						23d. Date	of deliver	У	
DA Box 6	requires that the death cert been signed by the attendir should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Other (sp		у				Mont	th [Day Ye	ear
3,0	that the ned by the e detach	by Ph	Part II. Other significant conditions of	ontributing to death bu	ıt not resu	Iting in the (underlying o	ause giv	en in Part I.		23e. Did to	obacco u	ise contrib	oute to the	cause of de	ath?
A.A.	law requires has been signe 2 should be										1 🗆 🗅	Yes 2	□ No 3	B 🗆 Proba	ably D	Inknown
DRAZIN/ Records, P.O.	law nas e 2	Completed								_ [24a. Was a	osy	pri		sy findings av	
	0		25. Was case referred to medical					26 DI	ace of Death (0	Chook only	1 Yes	Thed No		Yes 2	! □ No	
of Vital	ysicia is cert direct	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital: Inpatie	nt 2 🗆 E	R/Outpatie	nt 3 🗆 DO	Othe				dence 6	Other	(Specify)		
of	ng fter une		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day,		8b. Time o injury		Bc, Injury work	at ?	28d. [Describe h					
sior	Attending or death. ector: After by the fune	Certificate:	2 Accident Investigatio		ov - At hom	ne farm str	M eet factor		Yes 2 No	_	ocation (S	Street and	d Number	or Rural F	Poute Numbe	ar.
Division	ital or A urs after al Dire		building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check 2 L Medical Exam	sician: To the best of n iner: On the basis of ex se Practitioner: To the	amination:	and/or inves	tigation, in r	ny opinio	n, death occur	red at the ti	me, date a	nd place,	, and due t	to the caus	e(s) and man	ner stated.
	To th		29b. Signature and title of Cortifica	1001	./.4	NA		. License	number		$\overline{}$	29d. Dat	te signed (Month, D	ay, Year)	
	10+1		30. Name and address of person who	Completed course of de-	ath /ltom (39) /11/22	MLP Print\	7	>6512	->		4	(4)	100	12	
			Amirali Nader, N	1.D., 8600	Old (Georg	etown	Roa	d, Beth	resda	, Mar	Lylar	nd 20	814		
	Stat	٠ ١	31. Date filed (Month, Day, Year) MAY 0 2 20	32 Registrar		re 🙍	فيد									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deathpm 10:15 M 2. Date of Death Physician/ Umana Diaz Appril 104, 2012 Rosa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery 1115 West Nolcrest Drive 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8 Date of Right 9. Birthplace (State or Foreign Hours 9140119911945 219-11-9916 66 Equits alvador 1 □ M 2 🔀 **Director** 28a-f show with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits notified at Director MD Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? must be Funeral items 23a 1115 West Nolcrest Drive 20903 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

ELSalvadoran

1 ▼Yes 2 □ No Specify: 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc.
White o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marcelina Felipe Umana Medina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 1115 West Nolcrest Drive Silver Spring, Md 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Erica Diaz/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gate of Heaven 4/16/2012 Silver Spring, Md 4 Donation 5 Other (Specify) Signature PHILIPADO FINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive heart failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last iding physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 month Month Pregnant at time of death signed by the at be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ atrial fibrillation, chronic kidney disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? diabetes, hypothyroidism 24a. Was an page 2 autopsy perform 2 X No 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ပ ER/Outpatient 3 DOA 1 Inpatient 2 funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending after death. 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D

gompletely filled Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2012 MD036400 is person who completed cause of death (Item 23a) (Type, Print)
Ramsay M.D. 106 Trying 30. Name and address Gordon 106

Registrar

State

31. Date filed (Month

MAY 0 2 2012

Irving Street NW

Washington, D.C.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 0.5 02 8:00 AM Jacqueline Pretot Dorsett Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 135 24 3738 **Director** 1 🗆 M 2 🗓 F 81 06/27/1930 New Jersey 28a-f show with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Anne Arundel 1 Yes 2 X No Annapolis 10e, Street and Numbe 10f. Zip Code ō 10g, Citizen of What Country? ms 23a or must be Funeral 11 Bay Drive 21403 USA items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò by 1 Never Married 2 X Married 1 Yes 2 If Yes, Give filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of rother traumatic ever မ Armand Pretot Myrtle Hankins 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is:
any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra D. Jeffery/Daughter 44943 Oak Forest Dr, Northville, MI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematorý 5/3/12 Alexandria, VA 21. Signature 22. Name and Address of Facility Advent Funeral Services M00839 7211 Lee Highway, Falls Church, VA 23a. Part 1. Er or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or Immediate Caus (Final Physician/ Bowel perforation disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Ovary CANO Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Month Pregnant at time of death 5 Other (specify) Dav Year the Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has 2 🗆 No 1 Yes Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be In ALTEN ! examiner? Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Investigation upletely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Funeral 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the only one) 29d. Date signed (Month, Day, Year) DS2830 may unine

Registrar

DHMH 17 Rev 06-2011

2003 Medical

Parixy

Name and address of person who completed cause of death (Item 23a) (Type, Print)

filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland				Mental Hy	21	112	15752		
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death					Reg. No. 2. Date of Death 3. Time			
	Physicia Medic		Henri Jerome Dingle				April	26, Day 201	2 ^{Year}	11:52 A M		
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or			4c. County of Death				
na s	Francis		4137 Southern Avenue # 102 5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year	tal Hei			ince George's 9. Birthplace (State or Foreign			
	Funeral Director		579-82-8191 1™M2□F	Months Days Hours Min			(Month, Da	ay, Year)	Country)			
	d d	Funeral Director	Usual Residence of Decedent 49 10a, State 10b, County 10c, City	, Town or Loc	eation		Dec. 13	3, 1962	Maryland 10d. Inside City Limits			
	arylan a-f sh fied a			, lowing Eo		ital Hei	ghts			1 Xyes 2 □ No		
	the Ma or 28 e noti	ä	Maryland Prince George's 10e. Street and Number		10f. Zip Code		0	10g. Citizen of	What Count	ry?		
	s 23a	eral	4137 Southern Avenue # 102		20	743		Unit	ed St	ates		
	death r item iner r	/ Fur	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - America ck, White, e			
36	al", or	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Serviced 4 Divorced Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify: African American				
21215-0036	hour natur	To Be Completed	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupa		kina	16b. Kind of Business/Industry				
2	hin 72 ne. than "		Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do	O NOT use retired)	_	ning .	Self-Employed				
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Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		Jefferson Dingle Jr.		Flossie Sparkman							
lary	should and N is ma auma		19a. Informant's Name/Relationship (Type, Print)	1					y or Town, State, Zip Code)			
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altimore,	age 1 and of H		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, cren hingto	sition (Name of natory or other place n Nationa	May		20c. Location	,			
를	nit. Pa artme ortan injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Servin Licensee	<u>Cēme</u>	tery . Name and Addres		012 Stewart	<u> Suit</u> Funeral		Maryland Inc.		
ñ	permit Depar Impor any in	7	John T. Stewart M00560		4001 Benn			shington		20019		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
~1	Medical	1	Immediate Cause (Final disease or condition Hypoxia Onset and Death									
-m/2	Examiner		resulting in death) Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease									
		ner	Due to or as a consecu		CIVE I GIN	Conary D.	LBCabc					
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c									
_	cate be executed physician and s the burial-transit	alE	resulting in death) Last Due to (or as a consequ	ence on:								
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89	ending r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Feta	v			23d. Date of delivery					
B0)	the att	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown in the past 12 months? 4 Pregnant at time of d		M	Day Year						
Division of Vital Records, P.O. Box 687	requires that the death certific been signed by the attending is should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause									
S, F	uires ti n signe uld be	ed by								ably 4 🗌 Unknown		
Sorc	iw requ	plet	Diabetes Mellitus - Type 2						24a. Was an autopsy available prior to completion of cause of			
Be	Attending Physician: The law rary death. ector: After this certificate has but the funeral director, page 2 st	Be Completed					perl 1 🗆 Yes	ormed? 2 🔀 No	death? 1 Yes	2 🗆 No		
ta	ician: pertific rector,		25. Was case referred to medical examiner? Column									
of <	Phys ir this eral dii	e: 10	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 C									
ono	ath. r: Afte ne fun	icat	1 🔀 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident □ Investigation	M 1 □	? Yes 2□No							
NISI	or Atte fter de irecto n by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hobiding, etc. (Specify,		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 X Certifying Physician: To the best of my knowle	edge, death	occurred at the time	, date and place	and due to the	cause(s) and man	ner as state	d.		
	ne Hor in 24 h ne Fun pletely	Medical	(Check only one) 3 Certifying Nurse Practitioner: To the best of m	and/or inves	tigation, in my opinio	n, death occurred	at the time, date	and place, and du	ue to the cau	se(s) and manner stated.		
	Vithi To th	-	29b. Signature and title of certifier	٠, ٨	29c. License	number		29d. Date signe	,			
	The state of		Indah Cum			1428		May	2, 2	012		
	4,		30. Name and address of person who completed cause of death (Item Linda D. Green M.D. 7582 Ann			anham, M	aryland	20784				
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signat							-		
	Registr	~	4									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Month (Physician/ Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death 405 Venton Road Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 577-58-0554 Director 1 X M 2 □ F 67 7/7/1944 Washington, DC Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Anne Arundel Deale 1 Yes 2 No 10e, Street and Number 5 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral must USA 785 Mason Beach Road 20751 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1961-65 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Hardwood Flooring Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Anthony DePhillip Audrey Hackshaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i 785 Mason Beach Road, Deale, Maryland 20751 Barbara DePhillip/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ; Department of H Important: If ite any injury or ot M Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 5/3/12 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature no Feneral, Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) months Medical Due to (or as a con-equence **Examiner** Sequentially list conditions Examine if any, leading to immediate cause E ter chaering Cause (Disease or injury Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth
Pregnant a in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SINUS CANCER Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown STROKE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 🗆 No 1 Yes filled in by the funeral director, • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ DANGHTER'S examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec ျှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury_at 1 Natural 5 🗌 Pending work? Accident Investigation 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 ... 29b. Signature and title of certifier 5/1/12 0 14774 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AZIZ M.D. 31, Date filed (Month, Day, Y

Registrar

State

gistrar's Signature

0 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Callaway Day PM Donald 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SALISBUR TIMINSHUM REGIONAL 100m100 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 9. Birthplace (State or Foreign **Funeral** Hours Country) 216-14-9107 Director 1**X** M 2 □ F 87 07/28/1924 Georgia Usual Residence of Deced or 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director notified Salisbury 1 Tes 2 K No Maryland Wicomico the 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe Funeral with 23a 21801 USA 408 Loblolly Lane must ! or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 X Widowed 4 Divorced White Completed Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) ith and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Certified Public Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor Mitchell Charles Day Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna C. Day/Daughter 7318 Boyer St., Philadelphia, PA 19119 27 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4/27/2012 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licenses 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Myclodyspicisho Dil to (or as a contractice of): Immediate Cause (Final Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, sading to include cause. Enter Underlying Examiner Due to for as a consequence of the burial-transit Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death be detached g Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy perform 2 X No 1 Yes 2 No Yes the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🕱 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: After 1 X Natural injury 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 2 Acciden
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗷 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

10 IVA

HILAMA

30. Name and a

APR 27 2012

100 E. CARTOII Registrar's Signature

who completed cause of death (frem 23a) (Type, Print)

4.25.12

Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ERWIN AVONTE nan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UNIVESITY OF MARYLAND MEDICAL RAUTEMORE Daltimore If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Min. 219.62.873 Director 1 ☑ M 2 ☐ F 56 25.1955 MU show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Xent Jorton me 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with USA 25579 9 21678 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: 3 Widowed 4 Divorced HACK Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cagles metal worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ၉ Charles W. Dorsey DAEBARAY, MORDY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 5579 Stillford Teek Rd Worton, md DAIDARAY. VOrset- mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State union United methodist 5.5.2012 worton, md 4 Donation 5 Other (Specify) 22. Name and Address of Facility LANEL WALLEY FUNELOL SERVICE 21. Signature of Funeral Service Licensee Ha 1922 Forest Dr. Annapolis, Maryland 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Deosis Due to Medical Examiner Premotosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of for use as the burial-transit arroan arten and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending physiciar or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Cardiomyopathy 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Myocardial Infarction 24a. Was an has autopsy funeral director, page 2 performed? within 24 hours after death,
within 24 hours after death,
To the Funeral Director. After this certificate I completely filled in by the funeral director. Dans 25. Was ca referred to medical examiner? 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) 2 No Hospital Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 27. Manner of Death 28b. Time of Medical Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 2 K112680

State Registrar , Bathmore, MD

se of death (Item 23a) (Type, Print)

22 South Green St

32. Regis

Kathryn L Williams ACNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 15756

ias S. Exerci	For State Certificate of Death	Reg. No.
Physician/	egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death Day Year 1821 hrs
al Examiner	SILAS STEPHEN EXETER	May 3, 2012
	Ia. Facility Name (if not institution, give street and number) 4b. City, Town 16909 Aspen Leaf Court Bowie	o, or Location of Death 4c. County of Death Prince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign T, A.Y.O.I.I
Director	113-64-6003 1 M 2 F 55 Yrs. Months	Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Foreign LAYOU Country) MARCH 20,1957 ST. VINCENT
ĥ.	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<u> </u>	MD PG BOWIE	1 X Yes 2 No
nyland sa-f shnw at once,	10e. Street and Number	de 10g. Citizen of What Country?
th the Maryland 23a nr 28a-f shn notified at once. al Director	16909 ASPEN LEAF COURT 2071	
	11, Walital Status	f Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
or items must be	Never Married 2 Married 1 Yes 2 No	No specify: BLACK
21215-0036 Juld be filed within 72 hours after Mental Hygiene. marked rither than "natural", c event, the Medical Examiner To Be Completed by I	15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occ	supation (Give kind of work done 16b. Kind of Business/Industry
"natr	Elementary/Secondary (0-12) College (1-4 or 5+)	g life. DO NOT use retired)
5-0036 ed within 72 hour tygiene. Inther than "natu he Medical Exar Completed	3 SALES	PRIVATE
21215-0036 and be filed within 7 Mental Hygiene. marked nither than ic event, the Medica TO Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
121 d be fill ental I arked vent,	IRVIN EXETER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (CAROL M. LAYOU Street and Number or Rural Route Number, City or Town, State, Zip Code)
ID 21 should and Me 77 is ma	Tod. Information to the control of t	N LEAF COURT, BOWIE, MD 20717
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati	20a. Method of Disposition 20b. Place of Disposition (Name	of cemetery, Date 20c. Location - City or Town, State
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury nr other traumatic	1 X Burial 2 Cremation 3 X Kelloval Ion State DINCE MEM	ORIAL 5-12-2012 AJAX, ONTARIO
Baltimo permit. Page Department of Important: injury nr oth		dress of Facility POPE FUNERAL HOMES, P.A.
Dep Dep III	Klith (Sarge Molas) 5538 MA	RLBORO PIKE, FORESTVILLE, MD 20747
Physician	23a. I art I. Enter the disease, or complications the caused the death. Do not enter the mode of defailure. List only one cause on each line.	Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascu Due to (or as a consequence of):	lar Disease
	h	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
ed nsit Examine	Cisease or injury that initiated events resulting in death) Last but to (or as a consequence of):	
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	d	
60, ate be execut ohysician and he burial - tra	x unpended ☐ AMENDED 23a, 27, per me, g927 5	-18-12 sm
760 Ticate to g physicate but	FFEMALE: 23c. If yes, outcome of pregnancy	3 Ectopic pregnancy Month Day Year
Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be executed an all pirectors. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transitional and transitional and the perfector of the perfector	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
BOY e death the att	1 Yes 2 No 9 Unknown 9 Unknown	ause given in Part I. 23e. Did tobacco use contribute to the cause of death?
that the ned by detach	Part II. Other significant conditions contributing to death but not resulting in the underlying of	1 Yes 2 No 3 Probably 4 ✓ Unknown
luires puires an sign		24a. Was an 24b. Were autopsy findings available
Records, The law requires ficate has been signage 2 should be		autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec The l ficate l	26	Place of Death (Check only one)
ician: ician: icector	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DO	A Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene
Ision of Vita Attending Physicia ar death. Therefore After this cer by the funeral direct	27. Manifer of Death	c. Injury at Work? 28d. Describe how injury occurred
on cuding ath.	1 X Natural 5 Pending	1 Yes 2 No
VISI or Att frer de Directe in by 1	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, c	office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division o	4 Homicide determined (Specify)	the and place and due to the course(s) and manner as stated
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Inneral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached in the funeral director.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the ti (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my or	me, date and place, and due to the cause(s) and mainter as stated. pinion, death occurred at the time, date and place, and due to the cause(s)
To the Ho within 24 1 To the Fu completely	and manner stated.	License number 29d. Date signed (Month, Day, Year)
and I	·	O.C.M.E. May 4, 2012
72	30. Name and address of person who completed cause of death (Item 23a)	
1	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street	
Sta Registr		2012 Jenes S. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 2 U State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 2.50 Am Month Physician/ Medical **Examiner** urnie 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under **Funeral** Months Hours 68 045-34-0279 1 🗆 M 2 🗶 F **Director** Sept. 13,1943 Connecticut 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Arnold 1 Yes 2 X No Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21012 USA 102 Bark Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify White Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) t of Health and Mental Hygiene. If item 27 is marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Secretarial 12 Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Cassie Payne Friend Everett Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Bark Court Arnold, MD 21012 John Timothy Erdman/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 01, 2012 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory, INC. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter th ilure. List only one cause Immediate Cause (Final Phytician/ days disease or condition resulting in death) Medical **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examin for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Medical Certificate: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant been signed by should be detac page 2 funeral director,

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be s after death. filled in by

State

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)	Month Day Year
Part II. Other significant conditions		bacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
	24a. Was a autop perfor 1 □ Yes	
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 Yes 2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resid	ence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	(Month, Day, Year) injury work? ion M 1 ☐ Yes 2 ☐ No	ow injury occurred
3 Suicide 6 Could no 4 Homicide determin		treet and Number or Rural Route Number, n, State)
29a Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca	use(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

ompleted cause of death (Item 23a) (Type, Print)

Drive, Glen Burnie, MD 21061

Registrar

(Check

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month MAY SARA ANN **EYLER** 8:05A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Numbe **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 212-28-8964 1 - M 2XXF 79 **Director** Mary land 1932 Usual Residence of Decedent ms 23a or 28a-f shomust be notified at 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Coleridge Drive, Unit 2D 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 27 is marked of traumatic ever 2 William Edgar Wilson Sadie Ann Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10137 Baltimore National Pike, Myersville, Steven G. Eyler, son Health em 27 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Brook Hill Cemetery May 14, 2012 20c. Location - City or Town, State Frederick, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Ligensee ²² Neemend and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complicate ns that caused shock, or heart failure. List only one cluse on each line ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ eshiratory Onset and Death disease or condition Medical resulting in death) Due to (or s a consequence of): Examiner Years Sequentially list conditions, Examine if any leading to in recliations. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō Pregnant at time of death Month g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. היושו נחוס certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by Lung Cancer of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Coagulopal 24b. Were autopsy findings available prior to completion of cause of death? autopsy Ileus performed? Yes 2 No 2 \square No Hospital or Attending Physician: 24 hours after death. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 5 Pending Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide Investigation 2 🗌 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 07297 5/10/2012 leted cause of death (Item 23a) (Type, Print) Marius

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#8PerFH, G928, 6/17 2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARION **EDNA** FORD APRIL 2012 3:35 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3426 23RD PARKWAY TEMPLE HILLS PRINCE GEORGE'S Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1914 9. Birthplace (St Country) OCT 12, 2012 MARYLAND **Funeral** 9. Birthplace (State or Foreign Days Hours Director 219-16-1099 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important If item 27 is marked other than "natural". or item on any injury or other trainment. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 🕱 Yes 2 □ No MD PRINCE GEORGE'S TEMPLE HILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3426 23RD PARKWAY 20748 USA 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: BLACK Completed 3 X Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+ FOOD SERVICE GOVERNMENT 8TH Be 17. Father's Name (First, Middle | Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 RICHARD BENJAMIN COLBERT COROLINE SPENCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA BULLOCK - DAUGHTER 3426 23RD PARKWAY, TEMPLE HILLS, MARYLAND 20748 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) St. Luke's Mem. Cem. May 4, 2012 Upper Marlboro, Md 21. Signature of Funeral Se 22. Name and Address of Facility **JOHNSON** 716 KENNEDY STREET, NW, FUNERAL HOME N, DC 20011 & JENKINS FU WASHINGTON, 23a, Part 1. Enter the dis mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Approximate shock, or heart failu Interval Between Onset and Death Immediate Cause (Final Physician/ errent 18 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence on Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Dav signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed phods Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform rmed2 2 No this certificate 2 🗌 No 1 🗌 Yes ☐ Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) After 4 Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 Yes ☐ Accident 2 No Investigation 24 hours after deatl Funeral Director. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

State

7525 Greenway Center, Dr., #205, Greenbelt, Maryland 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin, Weitz, MD,

31. Date filed (Month,

MAY 0 42012

May 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month APRII 2012 AUSTIN LESLIE **GAVER** 3:30A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) 86 219-14-8818 Director 1 XM 2 - F June 29, 1925 Maryland 28a-f shov 10d, Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director must be notified Maryland Frederick Mt. Airy 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 1113 Meadowgreen Drive 23a Funeral 21771 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. 9 by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 nan "natural", c If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry د filed wn... خاط Hygiene. خات المال الم (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Head of audio visual NASA n and Mental Hygien other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Austin Wilfred Gaver Helen Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i Jay Gaver - son 1003 Meadowgreen Drive, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 \square Burial 2 ${\bf X}$ Cremation 3 \square Removal from State Stauffer Crematory 4-29-2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home of Funeral Service 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Buterial Onset and Death Immediate Cause (Final Physician/ pheumonic disease or condition resulting in death) Medical Due to (or as a consequence 1f) **Examiner** YROTS Sequentially list conditions. Examiner Due to for as a poinseque you of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown detached the ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No has page 2 after death.

Director: After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Suicide 1 Yes 2 No Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Molecular Print

FMH

31. Date filed (Month, Day, Year)

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Elaine Frances Gosey 2012 30 A^{M} 7:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Care Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** nth, Day, Yea Months Days Hours 214-48-0252 87 Oct. **Director** 1 M 2XX 1924 Maryland Usual Residence of Decedent 28a-f shov l0b. Count 10c City, Town or Location 10d Inside City Limits aţ Director Maryland Baltimore Baltimore Examiner must be notified 1 🗌 Yes 2 😾 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 715 Wilkens Avenue, Apt. CC322 21228 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. item 27 is marked other than "natural", or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Nursina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Charles Dobihal Katherine Chlad 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Gosey/daughter 909 Ravenshead Hill 21405 Sherwood Forest, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 5/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Mydlin 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, i i n/ Week disease or condition resulting in death) neumonia Medical Due to (or as a consequence of) Examiner cytopeni Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Syndrome -tran and that initiated events Due to (or as a consequence of) physician ar resulting in death) Last Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as. attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has performed? Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 29c. License number

12

State

CEDAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UDSE

MAY 0 1 2012

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COLUMBIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ April 26, 11:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 806 Terrie Court Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 94 |217-14-8562 1 X M 2 D F 11/17/1917 Maryland Usual Residence of Dec is than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 806 Terrie Court 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Navy/ Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates. AirCorp 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner/operator Steel/Metal Fabrication 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) Ralph Hall Grier Margaret Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann D. Grier/Spouse 806 Terrie Court, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Parsons Cemetery 4/30/2012 Salisbury, MD meral Service Lid AdTroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that cause the deflock, or heart failure. List only one called on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer mediate Cause (Final ASCVO Onset and Death Physician/ isease or condition resulting in death) 10 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) been signed by the ettending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica ours after death.

eral Director: After this certific filled in by the funeral director, Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number MMNahun APRIL 2715 2012 DR. USHA NATESAN 0051359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

SALISBURY

DIVISION ST

32. Registrar's Signature

SOUTH

2 2012

1415. 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Gibb III 101 Allan Tracy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HICOMICO REGIONAL SALISHUM MIDICAL If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 047-86-0918 Director 1 🗙 M 2 🗆 F 25 05/08/1986 Maryland Usual Residence of Dece Show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 X No 28a-f Salisbury Maryland Wicomico 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 'n Ith and Mental Hygiene. 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i USA 21804 Funeral with 316 Gunby's Mill Drive death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n|a Never Worked 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Melissa Marshall Tracy Allan Gibb II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy A. Gibb II/Father Health tem 27 316 Gunby's Mill Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once, 5/2/2012 Salisbury, MD Parsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association C 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Spindle Cell Caremona disease or condition resulting in death) Medical as a consequence of) Examiner Sequentially list conditions Examine day, leaching to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Day Year Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? After this certificate Yes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 M No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: To funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. I Director: Aft Accident Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State)

TO

within 24 hours a

To the Funeral I

completely filled

the

Medical

29a. Certifier

3 🗆

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 2. Registrar's Signature

Patoparla

Year)

29b. Signature and title of certific

Srvanthy

State Registrar

Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

IWE Camil Street Salishum MD 2180

29d. Date signed (Month, Day, Year)

2012

1 - For State Registrar

Grace

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Powell

4a. Facility Name (If not institution, give street and number)

HARRISON HOUSE NURSING HOME

Guettner

Funeral Director		5. Social Security Number 220–01–7330	6. Sex 1 M 2 X F		(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Birt (Month, Da	h V, <i>Year)</i> 1918	9. B Ma	irthplace (State or Foreign Country) aryland
ט		Usual Residence of Decedent											
ylan how	,	10a. State 10b. County	1	1	10c. City,	Town or Lo							10d. Inside City Limits
Mar Fed si	cto	Maryland Word	cester			Sno	w Hill						1 ☐ Yes 2 🕱 No
h with the 23a or 28a	al Director	10e. Street and Number 3732 Village	e Trail				10f. Zip Code 21863				10g. Cit	izen of What C USA	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar	If Yes. G	orces? 2 %] No ive			Was Decedent of I If Yes, specify Cub 1 □Yes 2 No	an, Mexicar	n, Puerto Rica	Yes or No- an, etc.)		Black, Wh	nerican Indian, ite, etc. White
72 hour "natural"	leted &	3 X Widowed 4 ☐ Divorced 15. Deceder (Specify only higher	Year or I nt's Education est grade completed,			(Give	dent's Usual Occu kind of work done	during mos	st of working		16b. Ki	ind of Busines	
ed within ygiene. ner than t, tre la	Completed	Elementary/Secondary (0-12)	College	1-4or 5+))		oo NOT use retire	,				I. Dupo	ont
uld be file Mental H Irked oth	To Be	17. Father's Name (First, Middle, Lambert Powell							er's Name (Fi ara Adl		Maiden	Surname)	
nd 2 shoralth and 1 27 is mastrauma		19a. Informant's Name/Relations Claire Ann Kir		er			ng Address (Street 2 Village						
ages 1 a ent of He it: If item y or othe		20a. Method of Disposition 1 Ma Burial 2 Cremation		State	cen	netery, crei	sition (Name of natory or other pla n Cemeter		Date 5/4/20	12		cation - City o	or Town, State
permit. P Departme Importan any Injur		4 □ Donation 5 □ Other (5 21. Signature of Funeral Service			10020	Ĥ	2. Name and Addre	ess of Facilit Funera	al Home	e Pro	fess	ional A	Association
442 6 6		23a. Part 1. Enter the disease, o shock, or heart failure. Lis'	or complications that t only one cause on	caused the	he death.	Do not en		ng, such as	cardiac or re	spiratory a		MD 218	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as a	conseque	/	thew	84	erog	5			Onset and Death
Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		conseque								
xecuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a	conseque	nce of):	·					_	
cate be e ohysician the buria			d			,							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 gnant at t	of pregnand 2 ☐ Fetal d time of dea	eath 3	☐ Ectopic pregnan ☐ Other (specify) _					23d. Date of o	delivery Day Year
ires that t signed by		Part II. Other significant conditi	ions contributing to	eath but	not resulti	ing in the u	nderlying cause gi	ven in Part I	I.		obacco Yes 2		to the cause of death? Probably 4 Unknown
law requass been 2 should	Completed									24a. Was	an	24b. Were	autopsy findings available to completion of cause of
The ate h	E									perfo 1 ☐ Yes	rmed?	death	?
lan: rrtific ctor,	Be (25. Was case referred to medica examiner?	al					26. Place	e of Death (C	heck only o	ne)		
nysic nis ce direc	10	1 Yes 2 No	Hospital: 1] Inpatien	nt 2 🗆 El	R/Outpatie	nt 3 □ DOA Ot	her: 42TN	ursing Home	5 ☐ Resi	dence	6 ☐ Other (S	pecify)
ath. rr: After the funeral	ation:	Z LI Accident	tigation	e of Injury nth, Day,	Year) 2	8b. Time o Injury	Wo	ıryat rk? ⊡Yes 2⊡		. Describe	how inju	ry occurred	
al or Atte safter de l Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	not be mined 28e. Plac build	e of Injur ding, etc.	y - At hom (Specify)	ne, farm, st	reet, factory, office		28f.	Location (City or To	Street ai wn, State	nd Number or e)	Rural Route Number,
e Hospitt 124 hours e Funera letely fille	Medical (29a. Certifier (Check only one) 1 Certifyi 2 Medica	ing Physician: To the Examiner: On the and ma	e best of basis of a nner state	examination	ledge, dea on and/or i	th occurred at the nvestigation, in my	time, date a opinion, de	and place, and eath occurred	due to the	cause(s date an	s) and manner nd place, and c	r as stated. due to the cause(s)
To th Fo th Somp	Me	29b. Signature and title of certific	er				29c. Licen	se number			29d. Da	ate signed (Mo	onth, Day, Year)
		▶\300mm	SARAD I	2- (BAR	LAL,	My D	54	422	-	l	4/27	/2012_
270		1604- Mar	n who completed cal	T- /	r's Signatu	(Type,	no ke	Md	218	5-1			
Sta Registr	ar	31. Date filed (Month, Day, Year	0010	egistidi eva) B.	po	ake						
HMH 17 Rev 1/2	001					OBIG	SINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

SNOW HILL

4b. City, Town, or Location of Deeth

Date of Death
 Month

Day

4c. County of Death

WORCESTER

April 27, 2012

3. Time of Death

0500

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	Oldio of III	arylaria / D	Certificate of De	eath	,	Reg. No. 2 (012 15765
ı	Physicia	n/	1. Decedent's Name (First, Midd					Date of Dea Month	Day	3. Time of Death
	Medic Examin	al	ARTHUR RINGGOLI 4a. Facility Name (if not institution			4b. City, Town, or L	ocation of Death	APRIL 3	4c. County	
	Examin	C1	111 CLEARSPRING			MILLINGTO	ON		QUEEN	N ANNE'S
	Funeral Director		5. Social Security Number 216-38-8940		e (In yrs. last birtha 71 Yr	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birt 01/24/	(941	9. Birthplace (State or Foreign Country) MARYLAND
	and show at	II. I	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town o	r Location				10d. Inside City Limits
	Maryla 28a-f s	Director	MARYLAND QUEER	N ANNE'S	MILLING	ron				1 ☐ Yes 2 X No
	th the	ai D	10e. Street and Number			10f. Zip Code			10g. Citizen of	
	ath wi	<u>~</u> r	111 CLEARSPRING	12. Was Decedent I	Ever in U.S.	21651 13. Was Decedent of His	panic Origin? (Spe	ecify Yes or No-		STATES ce - American Indian,
980	e filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ρ	1 Never Married 2 X Ma 3 Widowed 4 Divorce	If You Give	No	If Yes, specify Cuban, 1 ☐ Yes 2 X No		Rican, etc.)	Bla Specify	ck, White, etc. WHITE
2-0	2 hour "natu edical	plet		ent's Education hest grade completed)	((ecedent's Usual Occupat Give kind of work done du	tion uring most of work	ring	16b. Kind of E	Business Industry
21215-0036	within 7 giene. er than t, the Me	Completed	Elementary/Seconday (0-12)	College (1-4 or !	5+)	fe. DO NOT use retired) TS MANAGER			AGRICU	LTURE
d 2	filed wit al Hygier d other I	Be	17. Father's Name (First, Middle,	Last)			18. Mother's Nam	ne (First, Middle,		
Maryland	should be fil and Mental ' is marked' aumatic ev	임	ARTHUR RINGGOLI	D GARY, SR.			CARRIE R	EBECCA (GREENWO	OD
Mar	ge 1 and 2 should be tt of Health and Men tif item 27 is marke or other traumatic		19a. Informant's Name/Relation		1.0	Mailing Address (Street ar				
	and 2 Healt tem 2		MARGARET ANN GA 20a. Method of Disposition	ARY / WIFE	20b. Place of D	Disposition (Name of		Date Date		RYLAND 21651 - City or Town, State
Baltimore,	t. Pag trmer rtant njury		4 Donation 5 Other			VILLE U.M.	05/0			VILLE, MARYLAND
Bal	permir Depar Impor any ir once.		21. Signature of Funeral Services	Licensee		FELLOWS, H	ELFENBEI ROAD CHE	N & NEWI	NAM FUN N. MARY	ERAL HOME, P.A.
)	Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any models to include cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. Due to for as	a consequence of		IMA	ARCTI	ە 	Onset and Death
. Box 68760	that the death certificate be executed ned by the attending physician and e detached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	e of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,			pate of delivery Ionth Day Year
s, P.0	requires that the desorbeen signed by the solud be detached	þ	Part II. Other significant condi	tions contributing to death	but not resulting in	the underlying cause give	en in Part I.	23e. Did to		attribute to the cause of death? 3 Probably 4 Unknown
of Vital Records,	has has	Completed								. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
la		Be C	25. Was case referred to medic. examiner?	al Hospital:			ace of Death (Chec	ck only one)		
of Vi	Phys this ral dii	은	1 Yes 2 No 27. Manner of Death 12 Natural 5 Pen	1 ☐ Inpat 28a. Date of inj (Month, Date)		me of 28c. Injury	4 <u>□ Nursing H</u> at	28d. Describe	dence 6 🗆 Ot now injury occu	
Division	e at :: e	Certificate:	3 Suicide 6 Cou	rmined 28e. Place of In	jury - At home, farr tc. (Specify)	n, street, factory, office	163 2 1110	28f. Location (City or Tov		ber or Rural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th	Medical	Check 2 Medica	ng Physician: To the best o I Examiner: On the basis of ng Nurse Practioner: Jo the	examination and/or	investigation, in my opinio	 n. death occurred : 	at the time, date a	and place, and d	lue to the cause(s) and manner stated.
	2 Solution		29b. Signature and title of cell	ul El		29c License	06030	01	570	ed (Month, Day, Year)
	ms		30. Name and address of person	who completed cause of	death (Item 23a) (T	SPEZN RD	STE 5	CHESTA	Mou	11. m) 2/6/20
E	Sta Registr		31. Date filed (Month, Day, Year		rar's Signature	and the second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death April 30, Day 2012 Year Physician/ John Osborne Hedden 5:28 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Auxillary House If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year) Days Hours Director 156-14-0233 1 🕅 M 2 □ F 87 11/14/1924 New Jersey 28a-f show 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4200 Massachusetts Ave. NW Apt. 614 20016 United States death v 12. Was Decedent Ever in U.S. 13. W Armed Forces?

1 ▼Yes 2 No 4-1-1952 If Yes, Give 6-1-1956 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Yes 2 No Specify: White 3 Widowed 4 Divorced 6-1-1956 "natural", Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Finance Investment Advisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Shirley Skewis Albert H. Hedden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20016 4200 Massachusetts Ave. NW #614 Washington, DC Department of Healt Important: If item 2 any injury or other t Eleanor Hedden / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 05/02/2012 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Juneral Service Licensee ax 5130 Wisconsin Ave. NW Washington, DC 20016 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Previotan/ disease or condition resulting in death) Myocardial Infarct Medical Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of The law requires that the death certificate be executed Cause (Disease or injury Hypertension and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialattending physician (for use as the burial. Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1x Yes 2 No 3 Probably 4 Unknown Dementia, Adult Failure to Thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy performed Yes 2 K 2 🔀 No Assisted To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 4 Nursing Home 5 Residence 6 Nother (Specify) Living 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one)

State Registrar

29b. Signature and title

of certifie

Susan J. Miller MD

MAY 02

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

29c. License number

8218 Wisconsin Ave. Suite 305 Bethesda, MD 20814

D35579

05/01/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2037 PM 2012 4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 121-30-6484 1 M 2 X F 10/31/1939 NC 72 Usual Residence of Dece 28a-f show items 23a or 28a-1 snov ner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Upper Marlboro MD Prince Georges 10g. Citizen of What Country? Funeral 20772 AZU 9590 Crain Hwy . apt. d300 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Essie Taylor Willie Strong 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9590 Crain Hwy., apt.H300, Upper Marlboro, MD 20772 Albert Holman / husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burlal 2 Cremation 3 Removal from State Resurrection Cemetery 05/07/2012 Clinton, MD 4 Donation 5 Dother (Specify) 21. Signatur 22. Name and Address of Facility Strickland Funeral Services 4500 Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Anomiz disease or condition resulting in death) how Medical Examiner Sequentially list conditions cause (Disease or injury that initiated events Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage May discust 1 Yes 2 No 3 Probably 4 Unknown corinary artery 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No peripheral arterial disease 24a. Was an has performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation filled in by the 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral I

completely filled Medical 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ma 2012

DHMH 17 Rev 06-2011

State Registrar Parha

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012^{Year} Physician/ 28^{Day} April Marjorie Vetter Hoffman 8:00 \mathbf{P} M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Golden Living Center Frederick Frederick 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Hours 220-10-5299 91 **Director** 1 □ M 2 🗓 F Yrs Feb. 20, 1921 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State Directo Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6012 Quartet Lane 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Vetter Myrtle Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shat of Health a Leif Hoffman (Son) P.O. Box 471, 46 E. Water St, Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 5/1/2012 4 Donation 5 Other (Specify) Smithsburg, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 E. Church Street, Frederick, Maryland 21701 Dece MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final MITERY DISEASE OF CONOLAMY Physician/ MHENO SCLENC SIS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 X No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After the din by the funeral 28b. Time of 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural Accider 5 Pending work 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05-01-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tREDERICK. 814 KAZMI Mn BTE Date filed (Month State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 29, 2012 Year 8:14 р м Melvin L. Hackman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bowie Heartfields Assisted Living If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours 228-34-5147 85 1 XM 2 □ F **Director** Virginia Jan. 8, 1927 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Director 1 X Yes 2 □ No Bowie MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 within 72 hours after death with U.S.A. 7600 Laurel Bowie Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No WWII

If Yes, Give
Year or Dates. Marines Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 nan "natural", c 1 Yes 2 X No Specify Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. 27 is marked other than "1 traumatic event, the Med Department of Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Engineer the Navy permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Hattie Knight Lee Roy Hackman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7600 Laurel Bowie Rd., Bowie, MD 20715 19a. Informant's Name/Relationship (Type, Print) Vivian S. Hackman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State rial 2X Cremation 5-2-2012 Baltimore, MD Metro Crematory 4 Donation 5 Dothe 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ancer Ue/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chenta 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, page Yes 2 🔀 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? assisted low Other: 1 Tes 20 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural work? 1 🗌 Yes 5 Pending Accident
Suicide 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

Registrar

10

X

State

30. Name and address of person who

31. Date filed (Month, Day,

epmpleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #30 PER MD G930 8/16/12 TRT Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ -30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Samaritan BOUTIMOND Hospital MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Min 217-48-2411 **Director** 1 X M 2 □ F 64 8-2-1947 Maryland iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD 1 X Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3744 Ravenwood Avenue 21213 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ "natural", or 1 X Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Completed 3 Widowed 4 Divorced Specify. White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important; if item 27 is marked other than any injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4 or 5+) Commercial Sales Atlantic Fence & Supply Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Afton H. Hobbs - Mother Buena Vista Avenue, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parsons Cemetery 5-1-2012 Salisbury, Maryland gnatur f Funeral Service Licens Bounds Funeral Home Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Between Immediate Cause (Final set and Death Physician. disease or condition resulting in death) 304 Medical Due to (or as a consequence of) Examine 50 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury Cholic that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months? Pregnant at time of death Month 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mailor 2√ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No ☑ Inpatient 2 □ ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury,at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239 HUNDE TUIU 31. Date filed (Month, Pay, Year) State Registrar's Signature parke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar		Cer	tificate of D	Death		g. No. 20	12	15//
	Physicia	n/	Decedent's Name (First, Middle, Las	t)				Date of Death Month		Year	3. Time of Death
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	Funeral Director		577-52-2714 1	□ M 2 % F	Yrs.	Months Days	Hours Min.	(Month, Day, Y		Country	TN
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	or 288 notif	Director	10e. Street and Number	nico S	balist	10f. Zip Code		10	g. Citizen of W	hat Countr	y?
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Baltimore,	permit, Page 1 a Department of I Important: If its any injury or of	- 4	21. Signature of Funeral Service Licens	1000		. Name and Addres		3 40.00	Chinco	teagi	E, VA
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of V	Physer this eral d	e: To	27. Manner of Death	28a. Date of injury	28b. Time o	f 28c. Injur	ry at	28d. Describe ho			
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	Hosp 24 ho Fune etely i	edic	Check 2 Medical Exam	ysician: To the best of my knowniner: On the basis of examinations: To the best of	on and/or inves	stigation, in my opini	ion, death occurred a	at the time, date and	d place, and due	e to the cau	se(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Σ	only one) 3 🗷 Certifying Nui 29b. Signature and title of certifier	SO F FACINIONEL TO THE DESCO	my knowledge	29c. Licens			9d. Date signed		
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	STO		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)		111. 11	41.0	12	
مير)		TANYA CLIFFOLD 31. Date filed (Month, Day, Year)	CRNP 10	00 8	MATTOIL S.	7. SHC	130414	7110	211	70 /
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2012 8:20 P M Joel Junior Johnson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 37399 River Springs Road Avenue St. Mary's 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under **Funeral** Days **Director** 374-34-9236 1 🕅 M 2 🗆 F 74 Yrs. 10/22/1937 Lake Orion, MI Usual Residence of Deced or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD St. Mary's Avenue 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ems 23a or must be r Funeral 37399 River Springs Road 20609 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, ian "natural", or ite Armed Forces? Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " rent, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withi.
Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the Nonce. 12 Command Master Chief U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Joel Johnson Rubye Carnahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene Farrall/Companion 37399 River Springs Road, Avenue, Maryland 20609 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mary Land
Veterans Cemetery 05/11/2012 |Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Signatur C.Ech √#M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Elber the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death no Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 □ No 3 □ Probably 4 □ Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? After this certificate 1 Yes Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred s after dec. al Director; Afte 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

the Hospital within 24 hours a State Registrar

DHMH 17 Rev 06-2011

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 0 8 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avani D. Shah, 22650 Cedar Lane Court, Leonardtown, Maryland 20650

Registrar's Signatur

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

7066

29d. Date signed (Month, Day, Year)

. 12

Registrar

DHMH 17 Rev 7/2009

State

20650

ZSSOO POTINT LOUNCHT DOMB LECTIMEDTHIN MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEBSON MD

Registrar's Signature

BRUCE ROBERT

MAY 11

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KORITZER Day 26 Year 2 Month ICHARD 50M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number Year If Under 24 Hrs. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours Days 216-20-9833 85 Director 1 XM 2 □ F Nov. 27,1926 Maryland or 28a-f show notified at the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ral", or items 23a or Examiner must be by Funeral 7367 Furnace Branch Road 21060 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?

KN Yes 2 □ No WW II Black, White, etc. 1 Never Married 2 Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White "natural" 3 X Widowed 4 Divorced Specify Completed Year or Dates ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ marked Edward J. Koritzer Anna Langenauer and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 573 Henderson Road Bel Air, MD 21014 Page 1 and 2 Jacauelin Keleman/ Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State May 02, Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) MD Veterans Cemetery Crownsville, MD Donation 5 Other (Specify) 2012 Signature of Lunga Service Licensee 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Severna Park, MD 211 495 Ritchie Hwy, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Final In. Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE nse s, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ρ in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death detached ☐ Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 No has After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: ၉ 1 Yes XER/Outpatient 3 DOA 1 🔲 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Abert, M.D. 301 Hospital Drive

Glen Burnie, MD 21061

29d. Date signed (Month, Day, Year,

31. Date filed (Month, Day, Year) gistrar's Signature MAY 0 2 2012

(Check only one)

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryl				lental Hy	giene	012	15775
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of L	Death		Reg. No.	UIZ	13113
	Physicia		Pearl Loesberg				2. Date of Dea	29, 20	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	r Location of Death	Арлис	4c. Count		10:30P ^M
4			4028 Wood Swallow			ırtonsvill	Le	70. 000110	,	tgomery
	Funeral		F = 10 0C11	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt			ace (State or Foreign
	Director		577-42-2841 Usual Residence of Decedent	79 Yrs.				5/1933		ington, DC
	land show dat	tor		City, Town or Lo	ocation				10	0d. Inside City Limits
	Mary 28a-f otifie	irec	Maryland Montgomery			Rockvill	e			1 🗌 Yes 2 🗓 No
	th the 3a or t be n	Funeral Director	10e. Street and Number	,	10f. Zip Code	00650		10g. Citizen of		, I
	ems 2	nne	5800 Nicholson Lane, #308		Was Decedent of H	20852	cify Yes or No-	14 Pa	U.S.	
တ္တ	ter de , or its imine	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No			lispanic Origin? (Spean, Mexican, Puerto I	Rican, etc.)		ck, White, e	
8	tural"	Completed	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🛣 No			Specify	/: U	1hite
15	72 hc in "na Aedic	nple	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of working	ng	16b. Kind of E	Business/Ind	ustry
212	within giene. er tha er tha		Elementary/Secondary (0-12) College (1-4 or 5+)			inistrator			Real	Estate
nd	filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name				
ry la	uld be d Men marke natic		Ralph Blacker					thy Fri		
Maryland 21215-0036	2 sho Ith an 27 is r r traur		19a. Informant's Name/Relationship (Type, Print) Richard Loesberg - Son			and Number or Rura llow Cour				
Ē,	1 and of Hea item othe		20a. Method of Disposition 20	b. Place of Dispo	osition (Name of		ate Durit	20c. Location		
imo	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland fartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at it.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	t. Leban	matory or other plac on Cemete	ery 05/02	/2012	Adelp	hi. Mo	vryland
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other:		21. Signature of Funeral Service Licensee MBW CCMO 14	015201	2. Name and Addres	ss of Facility Hir Hampshire	ies-Rina AveS	aldi Fu ilver S	neral	Home, Inc.
			23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.							Approximate Interval Between
and I	hymician/		Immediate Cause (Final disease or condition Metasta:	tic Rena	l Urothel	Lial Cance	r		3	Onset and Death Vears
A. A	Medical Examiner		resulting in death) Due to (or as a cons	sequence of):						
		ner	Sequentially list conditions, b. Enable (cross continuous)	sactilenite ut)						
	anted Did	Examiner	cause, Enter Underlying Cause (Disease or injury that initiated events c.					_		
	ite be execute hysician and the burial-	al E)	resulting in death) Last Due to (or as a cons	sequence of):						
760	cate b physic	edical	d							
89	eath certifica attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre		7			23d. Da	ate of delive	~
Box 687	death ne afte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🔯 No 2 ☐ Helstrouw 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time		Ctopic pregnand Other (specify)	ЭУ 				Day Year
o.	at the d by th letach		9 Unknown Part II. Other significant conditions contributing to death but not	resulting in the I	inderlying cause giv	ven in Part I	220 Didto		hullarida da das	e cause of death?
Division of Vital Records, P.O.	requires that the de been signed by the should be detached	d by	3	100011119 111 1110	and onlying oddoo gi	VOIT IN T CAPE II.				ably 4 🕱 Unknown
ord	w requ	Completed					24a. Was a			sy findings available
Rec	The law ate has page 2	Com					autop perfor	rmed?	prior to con death? 1 \sum Yes	pletion of cause of
ta	Physician: T this certifica ral director, p	Be	25. Was case referred to medical examiner? Hospital:			ace of Death (Check				
<u> </u>	Physi rthis c eral dir	<u>년</u>	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatie		4 L Nursing Hor		lence 6 X Oth		Son's Home
ou c	nding ath. r: After	icate	1 ☑ Natural 5 ☐ Pending (Month, Day, Year 2 ☐ Accident Investigation		work		od. Describe n	ow injury occur.	rea	
/ISI	or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		eet, factory, office	2	28f. Location (S City or Tow	itreet and Numb	er or Rural F	Route Number,
۵	pital or ours afte eral Din filled in	_								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial funeral transfer.	Medical	29a. Certifier 1 X Certifying Physician: To the best of my kr (Check 2 Medical Examiner: On the basis of examinonly one) 3 Certifying Nurse Practitioner: To the best	ation and/or inves	tigation, in my opinio	on, death occurred at	the time, date a	nd place, and du	e to the caus	se(s) and manner stated.
	Voint No to	3	29b. Signature and title of certifier		29c. License			29d. Date signe	d (Month, D	ay, Year)
	2		, , ,			ND037179		Мау	01, 2	2012
			30. Name and address of person who completed cause of death (Jeanny Aragon-Chang, M.D.,			a Aue., NW.	Washing	gton, D	C 2003	37
	Stat Registra		31. Date filed (Month, Day, Year) 37. Registrar's Signature (MAY 0 2 2012)			,	•	· · · · · · · · · · · · · · · · · · ·		
			LINI A COLF. COMPANY	E . (1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 15776

1- For State Ce	rtificate of Death	Reg. No.	10/1
Physician/ 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
Medical Examiner Enrique Denis Lo 4a. Facility Name (if not institution, give street and number)	Za 4b. City, Town, or Location of Death	Month Day Year May 10, 2012	1750 hrs
8662 Piney Branch Road	Silver Spring	Montgomery	
Function 5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year If Under 24Hrs.		Birthplace (State or
Director $216-33-1445 _{1 \times M} _{2 \times F} 43$	Yrs. Months Days Hours Min.	6/15/1968 E	eign Ioun&alvador
Usual Residence of Decedent			
	Town or Location ilver Spring		10d. Inside City Limits
MD Montgomery S		T. au in	1 Yes 2 No
10e. Street and Number 8662 Piney Branch Road #	10f. Zip Code 20901	10g. Citizen of What Co	
			erican Indian, Black,
11. Marital Status 1 Married 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto El Salvadoro	Rican, etc.) White, etc.	
Widowed 4 Divorced If Yes, Give Year or Dates:	1 X Yes 2 No specify:	Specify: W	hite
15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of w during most of working life, DO NOT use retir		s/Industry
15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Father's Name (First, Middle, Last)	Landscape Worker	Lands	cape
12 Light within the control of the	18 Mother's Name	(First, Middle, Maiden Surname)	
Tancisco nector benitez	Ana Ce	lia Loza	
19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or R		
Dora Loza/Sister	3064 Bel Pre Road Place of Disposition (Name of cemetery,	#103 Silver S	
O = = =	crematory or other place)	Moncagua	a,SanMiguel
State to 4 Donadon 5 Other Specify:	eneral Cemetery 5/1	ET SULT.	
The second of th	PHILIP D. RINALD 9241 Columbia B	I FUNERAL SERVI	ICE,P.A.
Physician 23a. Part I. Enter the disease, or complications that caused the death			Approximate Interval
/Medical	The Liver		Between Onset and Death
or condition resulting in death) Due to (or as a consequence of	of):		
Sequentially list conditions, if any, leading to immediate b. Chronic Alcoho Due to (or as a consequence of			
Larry, leading to inheritate a but to (or as a consequence of cause. Enter Underlying Cause. (Disease or injury that initiated			
events resulting in death) Last Due to (or as a consequence of	f):		
The state of the s	7,per me,g927 5-18-12 sm	1	
MENDED 23a-b, 27		23d. Date of delive	erv
23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	the state of the s	Day Year
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 1 Live birth 4 Pregnant at time of de past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not re	5 Other (Specify)		
Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
Out that the page of the page		1 Yes 2 No 3 ✔ Pr	robably 4 Unknown
Records, The law requires fitcate has been signed 2 should be Completed			autopsy findings available o completion of cause of
he law on the hard of the law on the law of the law		performed? death?	?
The spiral of th	26.Place of Death (Check of		
So variable to the dictal through the special to the dictal through the special to the dictal through the special transfer to the dictal through the special transfer to the dictal transfer transfer to the dictal transfer transfer to the dictal transfer	ER/Outpatient 3 DOA Other Nursin	g Home 5 Residence 6 🗸 Oth	ner: Scene
The law required to medical examiner? 1	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Natural 5 Pending Investigation	1 Yes 2 No	206 Leasting (Charat and Number of	Duran Davida Normbay City
Could not be determined (Specify) Natural 5 Pending Investigation 28e. Place of Injury - At he determined (Specify)	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or For Town, State)	Rural Route Number, City
29a, Certifier	ge, death occurred at the time, date and place, and	due to the cause(s) and manner as st	ated.
1 Natural 5 Pending Investigation 28e. Place of Injury - At h 1 1 1 1 1 1 1 1 1			
29b. Signature and title of certifier	29c. License number	29d. Date signed (M	Month, Day, Year)
Jeto Valle Ville	O.C.M.E.	May 11, 2012	
30. Name and address of person who completed cause of death (Item		ro MD 24222	
	um you vy salimore street Kaltimo	IE. IVILI Z IZZS	
Victor Weedn MD JD Assistant Medical Exami State 31. Date filed (Month, Day, Year) Registrar 37. Registrar's Signar			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>012</u> Physician/ Evangeline Victoria Mazzolini April 28 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring Arcola Health & Rehab. Center Montgomery 9. Birthplace (State or Foreign Country)
NY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Oct. 19, 1920 1 🗆 M 2 🏝 F Months Days Min 579-16-9888 91 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10d. Inside City Limits Directo 1 Yes 2XXNo MD Montgomery Wheaton 10e. Street and Number 10f. Zip Code 109. Citizen of What Country? Funeral 11403 Sherrie Lane 20902 event, the Medical Examiner must USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Specify.White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Insurance Company is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Marinaccio Angelina Aiello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Robert Anthony Mazzolini/Son 2708 Finley Street, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 Removal from State Randolph, VT 4 Donation 5 Other (Specify) Pleasant View Cemetery F7 Name and Address of Earlitins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Serrice Licensee Kehardt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ freumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Box 68760 E FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnam 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death g 🗌 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Onknown HYPERTENSZON 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy perform 1 🗌 Yes 25. Was case referred to predical 26. Place of Death (Check only one) Division of Vital Be examiner? Hospital: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00064624 01, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

SANDERP SHAMMA 9701

31. Date filed (Month, Day, Year)

VEIRS

ROLLVELLE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Lee Miller 2012 April 11:23 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** 214-82-4531 Months Days Hours **Director** 1 XXM 2 □ F 50 Yrs. May 13, 1961 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 28a-f Edgewater 1 Yes 2XXNo 0 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1010 Mayo Road 21037 U.S.A. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 XXNo ori Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Woivorced Specify: White Year or Dates any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Self-employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arnold H. Miller Jr. Clara Lee Munday 19a. Informant's Name/Relationship (Type, Print) Arnold H. Miller, Jr./father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2320 Rutland Road Davidsonville, Maryland 21035 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2XX remation 3 Removal from State Baltimore Crematory 5/2/2012 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ğ in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the a d be detached f 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 I 3 DOA ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) : After t Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MARIA ROMERO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

DHMH 17 Rev 06-2011

To the !

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Norris 2012 2:50P Frances May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's 45933 Burns Drive **Valley Lee** Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 212-62-0044 Director 1 M 2 X F 74 09/24/1937 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 K No St. Mary's Valley Lee Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 20692 USA 45933 Burns Drive hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဂ္ Knott Sheehan Gladys Victoria James Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2660 N. Elizabeth Harbor Dr., Chesapeake, VA 23321 Donna Jean Scott/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕱 Burial 2 □ Cremation 3 □ Removal from State Ridge, Maryland 05/10/2012 4 ☐ Donation 5 ☐ Other (Specify) St. Michael's of Funeral Service Mattingley Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last tra Due to (or as a consequence of): buria attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Unknown the þ been signed the should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has page 2 s autopsy perfor death? Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(b) pne State

Jennifer Schmidt

NAY 0 9 2012

29b. Signature and title of certifie

30. Name and address

Prson who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

40900 Merchants Lane, Leonardtown, MD 20650

2 Registrar's Signature

Registrar

within 2 To the F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Margaret Bland Poling 2012 4:50 2, May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rebecca House Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min 257-14-6922 **Director** 1 🗆 M 2 🔀 F 93 January 28, 1919 Baxley, Georgia Usual Residence of Decedent 28a-f shov 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9910 River Road 20854 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) University of Elementary/Secondary (0-12) College (1-4 or 5+) Maryland Secretary 12 should be filed with and Mental Hygien 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Daniel Bland Gertrude Halman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Kristin M. Wise / Granddaughter 1613 Thomas Drive, Point of Rocks, MD 21777 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 5/5/2012 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Congestive Heart Failure Sequentially list conditions, it any, leading to inneceste cause. Enter Underlying xamine Dunito (or as a consequence of): executed Cause (Disease or injury that initiated events Hypertension burial-trar Due to (or as a consequence of): ŵ resulting in death) Last attending physician **Medical** that the death certificate be Hyperlipidemia Box 68760 the as IF FEMALE: nse Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🖾 No ρ Month Dav Year Pregnant at time of death 1 ☐ Yes ∠ ⊭ g ☐ Unknown the 9 Unknown P.O. q Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Group home 2 X No မ 1 Yes To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DCA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

Dr. Vinu Ganti,

MAY U TYUT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 06-2011

19529 Doctor's Drive, Germantown, MD 20874

29c. License number

D41162

29d, Date signed (Month, Dav. Year)

May 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death April 27 ay 2012 ear Physician/ 11:10 P M Randa11 Margaret Perry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laytonsville Montgomery 4330 Damascus Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Director 215-36-2809 74 Yrs. Feb. 26, 1938 Maryland Usual Residence of Decedent show 10b. County 10a. State 10c. City. Town or Location at Funeral Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No Maryland Montgomery Laytonsville 10e. Street and Number 10g. Citizen of What Country? U.S.A. 4330 Damascus Road 20882 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 12. Was Decedent Ever in U.S. ral", or iten Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 XMarried Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life, DO NOT use retired) Applied Physics alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Weapons Software Analyst Laboratory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Phillips Lee Goldsborough II Anna Lee Fitzhugh Worthington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Huntley H. Perry - Husband Laytonsville, Maryland 20882 4330 Damascus Road, tem 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematorium 4/29/12 4 Denstion 5 Other (Specify) Alexandria, Virginia Name and Address of 21. Signature of Fun ral Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland OVer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breast Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No for Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 2 Unknown should be detached the P.O. ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsv page 2 perforr death? 1 Yes 2 No 1 ☐ Yes 2X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospita Other: 1 🗌 Yes 2 🗆 Xlo 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 XNatural 5 Pending after death.

Director: Aff
d in by the fur 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completely f

5 State

Registrar

(Check

only one 29b. Signature a

31. Date filed (Month Day

Debrah Miller

DHMH 17 Rev 06-2011

ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CRNP

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

April 28, 2012

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

R143201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				tate of Maryland / D	epartment o	of Health ar	nd Mental Hygi	ene	
			State Registrar	(Certificate of	of Death	Re	eg. No. 2	12 15782
П	Physicia	n/	Decedent's Name (First, Middle, Last) Talana David Date				Date of Death Month		3. Time of Death
	Medic	al	John Paul Pet 4a. Facility Name (if not institution, give street	rovick	I an			28, 2012	
	Examin	er	704 Rusack Court	and number)	, ,	n, or Location of I ${\sf nold}$	Death	4c. County of Anne	Arundel
	Funeral	7	5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	fay) If Under 1	ear If Under 24		g	I. Birthplace (State or Foreign
	Director		217-76-7600 1 ₺ M	2 □ F 28 YI		ays Hours	Min. (Month, Day, Dec. 13		Gountry) Saryland
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			, , , , , ,	10d. Inside City Limits
	laryla 3a-f s iified	Director	MD Anne Arund						1 ☐ Yes 2 🛣 No
	or 28	١	10e. Street and Number		10f. Zip Co	de	10	Og. Citizen of Wha	
	s 23a rust b	Funeral	704 Rusack Court		210	12		USA	1
	death item		Δ	/as Decedent Ever in U.S. rmed Forces?	13. Was Decedent	of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, White, etc.
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	d by	2 DWidowed 4 D Diversed If	Yes 2 X No Yes, Give	1 ☐ Yes 2 🛚			Specify:	White
21215-0036	hours natura lical E	Completed	15. Decedent's Education		ecedent's Usual O	ccupation	1	16b. Kind of Busir	ness/Industry
218	iin 72 ie. han "i	dwo	(Specify only highest grade cor Elementary/Secondary (0-12)		Give kind of work d fe. DO NOT use ret	one during most of ired)	f working		,
12	iled within I Hygiene. other thar rent, the N	Be C		5+	Attorney			Legal	
Maryland	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last)				s Name (First, Middle, Ma	aiden Surname)	
Z	should to and Me is mark		Bruce P. Petrovick 19a. Informant's Name/Relationship (Type, Pri		Acilina Address (Ct	-	Milone	Ditu as Taura Ctat	- Zin Codel
	12 shoalth an alth an 27 is r trau		Mary Milone Jordan	1 100.1	-		or Rural Route Number, (rnold, MD 2	-	e, Zip Code)
Jre,	1 and of Hea item		20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other			20c. Location - Ci	ty or Town, State
ij	Page nent (ant: II		1 ☐ Burial 2 🄀 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Metro (Crematory or other Crematory	, INC.	2012	Baltimor	ce, MD
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Bungral Servinge Licensee	ms	22. Name and A Barranco 495 Rito	& Sons,	P.A. Sever	na Park	Funeral Home MD 21146
			23a. Pert 1. Enter the disease, or complication shock, or heart failure. List only one cause						Approximate
	Physician/		Immediate Cause (Final disease or condition	malisms	at he	oplasm	1 6	41	Interval Between Onset and Death
اريد	Medical Examiner		resulting in death)	Due to (or as a conseq e of)		- (A 3(**)
		er	Sequentially list conditions, b. —	Part E. Communication of the					
	ed nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or ex a consequence of)					
	xecut n and ial-tra	Exa	that initiated events c resulting in death) Last	Due to (or as a consequence of)	:			·	
09	aath certificate be executed attending physician and I for use as the burial-transit	dical	d						
	tificat ng ph e as th	Mec	IF FEMALE:						
Box 687	th cer ttendi or use	ian/	23b. Was decedent pregnant 23c. If in the past 12 months?		3 Ectopic preg			23d. Date of	
B	e dea the a	Physician/Me	1 Yes 2 No 4	☐ Pregnant at time of death☐ Unknown	5 Other (specif	y)		Month	Day Year
P.O.	requires that the des been signed by the s should be detached	y Ph	Part II. Other significant conditions contribut	ting to death but not resulting in t	the underlying caus	e given in Part I.	23e. Did toba	acco use contribu	te to the cause of death?
	uires t n sign uld be	Completed by					1 🗆 Yes	3 2 No 3	☐ Probably 4 ☐ Unknown
Division of Vital Records,	w required to the second to th	plet					24a. Was an		e autopsy findings available
Rec	Physician: The law r this certificate has aral director, page 2	Som					autopsy perform	ed? dea	r to completion of cause of th? Yes 2 \(\sum \) No
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner?	als.	2	6. Place of Death (100	N holas
<u> </u>	Physi this c	၉	1 Li fes 2 Li No	a. 1 ☐ Inpatient 2 ☐ ER/Outp			ing Home 5 🗆 Resider		Specify)
n 0	iding Phy th. After this funeral o	cate	1 ☑ Natural 5 ☐ Pending	(Month, Day, Year)	iry	njury at work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred	
Sio	I or Attendi after death Director: A d in by the f	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At home, farm				eet and Number o	r Rural Route Number,
<u>≤</u>	tal or rs afte al Dire		- Cotomined	building, etc. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 \(\subseteq Medical Examiner: Or	To the best of my knowledge, de the basis of examination and/or in	nvestigation, in my c	pinion, death occur	irred at the time, date and	place, and due to	the cause(s) and manner stated.
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12-03308 Richard Powers

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Alcohol Use	68760 ertificate b ding physic e as the bur		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnance	у		
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Physician/ Medical Examiner	Month Day Year Occasi	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 105 Trafford Drive Chestertown 4c. County of Death Kent	
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Lant: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
, MI	Doris Richardson/Wife 105 Trafford DR Chestertown, MD21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	_
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timen rithen rithen y or o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Signature of Funeral Service Licensee 24. Donation 5 Other Specify: International Funeral Home	-
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To the H within 24 To the Fu completel	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	O.C.M.E. May 5, 2012	
OUME	30. Name and addless of person who completed cause of death (Item 23a)	
5 m	Mary G. Repple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	** * * * * * * * * * * * * * * * * * *	
Registrar	MAY = 8 2012 Ligardo p. 7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 13, 2012 Physician/ Month Betty Ruby 5:05M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Egle Nursing and Rehab Center Allegany Lonaconing Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Year) April 21, 1930 Months Days Hours 220-05-1198 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ★ Yes 2 No Lonaconing Allegany Maryland 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? Funeral 21539 **USA** 57 Jackson Street permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Inforcant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Never Worked Never Worked 0 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Mattie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave Lauder - Guardian 57 Jackson Street, Lonaconing, Maryland, 21539 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date May 15. cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland, Maryland **Cumberland Crematory** 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final N Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): led by the attending physician and detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☒ No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Norsing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred Natural Accident injury work? 5 Pending 2 D No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

1 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND PI LINE B PER MD G928 6 127/12 TRT and / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2012 MAY Physician/ LAWRENCE L. SCHROTH, SR. 1:40 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kent Heron Point - Tolchester Wing Chestertown 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Dec. 1 Days Hours 1**X** M 2 □ F Louisiana 147-05-0440 94 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director or 28a-f sl notified MD Kent Chestertown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P "natural", or items 23a or Funeral 21620 U.S.A. 501 East Campus Ave. Apt. 142 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1XXYes 2 \(\sum_{No}\) 1942 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Year or Dates. -1945 3 K Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plant Manager Paper Manufacturing 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jack P. Schroth Alice Marie Bidwell 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 213 Radcliff Dr. Chestertown, MD. 21620 Lawrence L. Schroth, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Kent Cremation Services 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5/7/12 Smyrna, DE. 4 Donation 5 Other (Specify) Funeral Bervio Galena Funeral Home of Stephen L. 118 West Cross St. Galena, MD. 21 M00510 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ck, or beart failure. List only one cause on each li Immediate Cause (Final disease condition resulting in death) Pnysician/ Medical Due to or as a consequence of) Examiner DEMENTIA Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Ortifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick Shanahan, M.D. 120 Speer Rd. Chestertown, MD. 32. Regist ar's Signature State Registrar

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П	Physicia	in/	Decedent's Name (First, Middle	,						2. Date of De Month	Da		Year	3. Time of Death	
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	Funeral Director		5. Social Security Number 219-14-4975	1 X M 2 □ F					Min.	8. Date of Bir (Month, Da 07/29/		9. Birthplace (State or Foreign Country) PENNSYLVANIA			
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	the Ma or 28 e noti	Dire	MD KENT 10e. Street and Number		MLLL	INGTO	10f. Zip Code			1	10g. Cit	tizen of W	hat Count		
	n with	Funeral	182 SASSAFRAS S	STREET			21651				UNI	TED S	STATE	S	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Marr	Armed For	dent Ever in U.S rces?	. 13. V	Vas Decedent of H FYes, specify Cuba	lispanic Or an, Mexica	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)			- America , White, et		
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Maryland	12 shoulth and 27 is m		19a. Informant's Name/Relationsh		TIME TO SERVICE THE PROPERTY OF THE PROPERTY O	1	g Address (Street							ode)	
	f Healt		DARLENE JOHNST(20a. Method of Disposition	ON / DAUGE	20b. Pl	ace of Dispo	BOX 47 N	- 1		Date		ocation - 0		vn, State	
mo	Page 1 nent of ant: If it		1 🗶 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		Clare	-	ON ASBURY		05/01	3/2012			•	MARYLAND	
Baltimore,	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Funeral Service L	icensee	, 1111		Name and Addre		7.7			11-17-			
	0 D ₹ 18 0		23a art 1. Enter the disease, or	complications that s	naugad the death	37	70 W. CYI	PRESS	ST.	MILLING	GTON	, MAI	RYLAN	D 21651	
Į,			shock, or heart failure. List o	nly one cause on ea	ch line.	. Do not ente	The mode of dyll	ig, sucii as	cardiac (or respiratory ar	rest,			Approximate Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a. Due to (or as a conseque	ence of):	HRIVE						-		
No page	Examiner	ı.	Sequentially list conditions,	b. PR	OFOUN	a De	condit	TON	NE		1				
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a conseque	ence of,.	100T 11		26	1.			,		
	executed ian and urial-transit	Exa	that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):	CE11 177	P—	200	***************************************	VED BY N	NEDICAL EX	AMINER		
90	cate be e	dical		d					CERT!	FICATION APPRO			_		
68760	ertifica ding pl	/Me	IF FEMALE:	23c. If yes, out	come of pregnan	ncv									
Box	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live I 4 ☐ Pregr	Birth 2 🗌 Fetal nant at time of de	death 3	Ectopic pregnand Other (specify) _	СУ				23d. Date Mon		Day Year	
P.O. E	t the deg by the g tached	Phys	9 🗌 Unknown	g 🗆 Unkn											
	res that i signed b		Part II. Other significant condition	_		ilting in the u	nderlying cause gi	ven in Part	. I.					e cause of death?	
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alF	ysician: The is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. P	lace of Dea	ath (Check	1 🗌 Yes k only one)	2 3 N	0	□ fes ∠	z 🗆 NO	
F Vit	Physic this ce al dire	은	1 X Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		Inpatient 2 - E			4 📙 N	-					CAREHOME	
0 0	Attending Pł r death. ector: Affer they the funeral	Certificate:	1. Natural 5 Pendin 2 Accident Investig		of injury th, Day, Year) 6, 2012	28b. Time of injury 9:47	28c. Injur work 1		- 1	28d. Describe h SUBJECT PERSON	PUS	SHED	BY Al	NOTHER	
Division	Hospital or Attending 24 hours after death. Funeral Director: After sted filled in by the fune	ertifi	3 Suicide 6 Could of the Could				eet, factory, office	_		28f. Location (S	Street an	d Number	or Rural F	Route Number,	
Di	oital o			NURS	ING HOM	E								LES STREET	
	To the Hospital or A within 24 hours after To the Funeral Directormpleted filled in b	Medical	(Check 2 Medical E		is of examination	and/or invest	igation, in my opini	on, death o	ccurred at	t the time, date a	and place	e, and due	to the caus	se(s) and manner stated.	
	To the comp	2	29b. Signature and title of certifier	. 0 0	\		29c. Licens	e number	o arra piac	c, and dec to the	29d. Da	te signed	(Month, D	ay, Year)	
	6		J. C. Clu	eas ,	JR- H.	1	02	388	9		ş	130	112	-	
	nst		29b. Signature and title of certifier 30. Name and address of person v 31. Date filed (Month, Day, Year)	who completed caus	e of death (Item	23a) (Type, P	rint)	+ 14	tasti.	term	7,7	110	210	20	
	Star	te	31. Date filed (Month, Day, Year)	32. Re	edistrar's Signatu	ure _	n si paci	1 017	2000	010000	110	-a	- , 0	and the same	
	Registra	ar	阿森 子 *** 9	2012 🔏	Post Billed	1. 1									

12-03303	Please Type or Print in Black Indelible In			0				
James Ray Sherro	1- For State Certificate of		ne 201 Reg. No.	2 1578				
Physician	Registrar 1. Decedent's Name (First, Middle,Last) The Company of		e of Death hth Day Year il 28, 2012	3. Time of Death				
Medical Examine	JAMES RAY SHERROD, JR. 4a. Facility Name (if not institution, give street and number)	b. City, Town, or Location of Death	11 28, 2012 4c. County of Deat					
	Prince George's Hospital Center	Cheverly	Prince Georg					
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. May 2. F 22 7. Age (In yrs. last birthday)	Months Days Hours Min.	INE 11,1989 9. Bit by 11,1989	irthplace (State or ountry) SHINGTON				
	Usual Residence of Decedent		JAE 11,1303 0	DC.				
w any	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No				
the Maryland to 28a-f sho iffied at once	NONE NONE WASHINGTOI	N, D.C.	10g. Citizen of What Co.					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3821 JAY STREET, N.E.	20019	UNITED STAT	TES				
ath with items 23	11. Marital Status 1 X Never Married 2 Married Armed Forces? 12. Was Decedent Ever in U.S. 13. Was If Ye	Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican,		rican Indian, Black,				
ter dear	1 Yes 2 A No	Yes 2X No specify:	Specify: BLA	ACK				
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36 nin 72 hour than "natu dical Exar	Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE UNEM	PLOYED	NONE					
215-0036 be filed within 7 mal Hygiene. rived other than ent, the Medica Be Comple	17. Father's Name (First, Middle, Last)	18.Mother's Name (First,	Middle, Maiden Surname)					
2121; Muld be fill Mental H marked ic event, i	JAMES RAY SHERROD, SR.	Address (Street and Number or Rural Ro	SE RICHARDSON	o Zin Code				
MD 21 d 2 should lth and Me n 27 is ma rumatic ex		OLD YORK ROAD, MITC	· ·					
re, No. 1 and f Health fittem or trau		tion (Name of cemetery, Date er place)	20c. Location - City o	r Town, State				
Baltimore, pernit. Pages I an Department of He Important: If ite	4 Donation 5 Other Specify: FT. LINCO		2012 BRENTWOOD	, MARYLAND				
Ball permit Depart Impor injury	21 Signature of Funeral Service Licensee LYPIA C. THORNTON JOHNSON MO0583	ORNTON FUNERAL HOME 39 LIVINGSTON ROAD.	, P.A.	MARYLAND 2064				
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure, List only one cause on each line.	e mode of dying, such as cardiac or respire	atory arrest, shock, or heart	Approximate Interval Between Onset and				
/ /Medical Examiner	Immediate Cause (Final disease a. Multiple Gunshot Wounds			Death				
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.							
	if any, leading to immediate Due to (or as a consequence of):							
= %		Disease or injury that initiated						
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ing Physician: The law requires that the death certificate be ex Affer this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial. On: To Be Completed by Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fet	al death 3 Ectopic pregnancy	23d. Date of deliver	ny Day Year				
ox 68 with certification or use a	past 12 months? 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Oth	er (Specify)		,				
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Rec The la ficate h,			performed? death? Yes 2 No 1 Y	es 2 No				
sician: sician: ls certifirector	25. Was case referred to medical examiner?	26.Place of Death (Check only one		er:				
Division of Vital Records, and or Attending Physician: The law require at fact death. After this certificate has been silled in by the funeral director, page 2 should be artification: To Be Completed	27 Manner of Death 28a Date of Injury 28h Time of In	jury 28c. Injury at Work? 28d. D	escribe how injury occurred					
Sion Attendi death. ector:	1 Natural 5 Pending Apr 28, 2012 0000 hrs	1 Yes 2 V No		ural Bouta Number City				
Division o epital or Attending nours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) Local Street	or	cation (Street and Number or R Town, State) ock of Kenilworth Terrence,					
To the He within 24 To the Pu complete!	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. 29b, Signature and type of certifier	on, in my opinion, death occurred at the tin	29d. Date signed (Mo					
	Pitto Dille Man Man	O.C.M.E.	April 29, 2012	· · · · · · · · · · · · · · · · · · ·				
00/2	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W	Baltimore Street. Baltimore MI	I D 21223					
State	31. Date filed (Month, Pey, Year) 32. Registrar's Signature							
Registra	MINI VILLE DE PORTO	THE RESERVE OF THE PERSON OF T						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Month Physician/ Dawn Michelle Seminuk P^{M} 28 1:15 Apri1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Spa Creek Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days (Month, Day, Year) Hours Min. Months 213-88-1030 39 Director 1 □ M 2 🗓 F Oct. 19, 1972 Washington DC Usual Residence of Decedent fshow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State aţ the Maryland **Funeral Director** notified 1 Yes 2 No Annapolis 28a-f Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō must be U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b once. 21403 35 Milkshake Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 X No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Barbara Clark William Frank Seminuk, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 40282 Waterview Drive, Mechanicsville, MD 20659 Kristine D. Baron/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metro Crematory ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4-30-2012 4 ☐ Donation 5 ☐ Other (Specify) Funeral Ser 22. Name and Address of Facility Beall Funeral Home R 6512 NW Crain Hwy, Bowie, Maryland 20715 ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onse and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 to 1 Yes 2 Month Day 5 Other (specify) Pregnant at time of death signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 3 Probably 4 Unknown 1 Yes 2 0 Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has t director, page 2 s autopsy performed Yes death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at nin 24 hours after death.

the Funeral Director: After in pletely filled in by the funeral 5 Pending injury work?
1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

Medical

29a. Certifier

only one) 29b. Signature and title of

3

30. Name and address of person who

Year

MAY 0 2 2012

Date filed (Month, Day,

within 2.

To the F
complet

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

201

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death SOFIA NICHELE Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director 213-32-6762 1 XM 2 - F May 14, 1931 Maryland 80 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 🗌 Yes 2 🔀 No MD Anne Arundel Arnold or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 328 Broadwater Road 21012 ıral", or items 2 I Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1953 Completed by 1 Never Married 2 X Married 1 X Yes : If Yes, Give 72 hours after 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural", 3 Widowed 4 Divorced 1961 Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ould be filed within 72 nd Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Barber Shop Barber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Sofia Carmela Pipito and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Giovanna Sofia/Wife 328 Broadwater Road Arnold, MD 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ay 4, 2012 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. Baltimore, MD Signature of Juneral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. 495 Ritchie Hwy. Severna Park Funeral Hom-Severna Park, MD 21146 Severna 23a Joint 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Seath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or **Examiner** IRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami ROKE and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown Yes 2 No 9 Unknown P.O. ate has been signed by page 2 should be detac Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy death? performed 1 ☐ Yes 2 ☐ No Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No ၉ 1 U Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 124 hours after death.

e Funeral Director: After this of the funeral director after this of the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1. Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Pracitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of Date signed (Month, Day, Year) an of death (Item 23a) (Type, Print) Name and address of pe who completed cau NNA POLISM D4401 N

Registrar

gistrar's Signature

32.

MAY 02 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1055 Charles E. Shockley, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICUMIED REGIONAL MEDICAL 504/36414 Peninsula If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Day, Yea 214-52-1084 60 Director 1 XM 2 🗆 F Jan 31, 1952 MD Usual Residence of Dec 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No Berlin MD Worcester 10g. Citizen of What Country? 5 10e. Street and Numbe 10f. Zip Code 23a Funeral 21811 USA 10262 Harrison Road items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Armed Forces Black, White, etc. o 1 Never Married 2 XMarried Completed by 1 ☐ Yes 2 ☐XNo If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 27 is marked other than "natural", traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed within 7 tal Hygiene. College (1-4 or 5+) Various Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F 2 Betty Derrickson Eltee Shockley, Sr. t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10262 Harrison Rd., Berlin, MD 21811 Linda L. Shockley/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ō Department of Important: If any injury or once. Calvary UMC Cemetery | 04/28/2012 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Metastatu Thywrd Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the burial-transit Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No ector: After this certification by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) e Hospital or Attenting Pi 124 hours after death. e Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work 1 Yes 2 🔲 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occur red at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIAVAMAY PATAPAILA M. 0 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

ORIGINAL

DHMH 17 Rev 1/2001,...,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 35PM Physician/ BRENDA ELAINE SCHMIDT Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Char Plat La ivista 7. Age (In yrs, last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min 7-17-1950 578-68-1879 61 WASH., D.C. 1 □ M 2 🔀 F **Director** 28a-f shov 10d. Inside City Limits 10a, State 10c. City, Town or Location Examiner must be notified at Director WHITE PLAINS 1 ☐ Yes 2 🔣 No CHARLES MD. 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number 23a Funeral 4606 DIAMOND RIDGE LANE 20695 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 12. Was Decedent Ever in U.S Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specif**WHITE** "natural", Completed 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ponce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 11th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P ALBERT HARVEY LUSBY EVELYN SANFORD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DANA CADY- P.O.A. 4606 DIAMOND RIDGE LN. WHITE PLAINS, MD. 20695 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ST. BARNABAS CEM. 5-15-12 TEMPLE HILLSMD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 7 day Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Year Month Day Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a Was an autopsy 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check Gartifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature 4 2012

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

MAY O

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24 2012 April 1 Doris Marion Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 20, 1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 204-03-7413 89 Director 1 □ M 2 🗷 F Pennsylvania Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location be notified at Director Maryland Carroll Mt. Airy 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 608 Merridale Boulevard 21771 must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Give Year or Dates. Black, White, etc 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. "natural", Specify 3[™] Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Education traumatic event, the Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bruce MacGregor Florence Stambaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code2177119a. Informant's Name/Relationship (Type, Print) Jeffrey Taylor -13403 Brandon Manor Court, Mt. Airy, Maryland 1 and 2 s of Health item 27 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place, ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4-29-2012 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home <u> 1621 Opossumtown Pike, Frederick, Maryland</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ULMONARY EMBOLISH disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ANCE LUNG Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the I IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy been signed by the atter in the past 12 months? Month ☐ Pregnant at time of death☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performed this certificate 1 Yes 2 No Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA Hospital or Attending Ph 24 hours after death. Funeral Director: After th 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 2 Accid 5 Pending work 1 Yes 2 No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD70022 24

3. Time of Death

10d. Inside City Limits

Onset and Death

Day

21701

Year

1 🔀 Yes 2 🗌 No

10:36 Aм

DHMH 17 Rev 06-2011

State Registrar

KACHEL

31. Date filed (Month,

Seventh Street, Frederick, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MADRIE

Year,

Please 1	ype or Print in Black Indelible Ink. Ensure A	di Copies Ar
For	State of Maryland / Department of Health and M	lental Hygien
State Registrar	Certificate of Death	Reg. N
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Æ	Examir		4a. Facility Name (if	not institution				4b. C	ty, Town, or	r Location	of Death		4	c. County	of Death		
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	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be ne tiffed at	Funeral Director	10e. Street and Nun					101.	Zip Code				10g. C	Citizen of W	/hat Cour	ntry?	
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Maryland	1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be n. tifled at		19a. Informant's Na	me/Relationsl	nip (Type, Print)		19b. Ma	ailing Addr	ess (Street a	and Numbe	er or Rura	Route Numb	er, City o	or Town, St	ate, Zip (Code)	
	nd 2 s lealth m 27		Michael J	. Tram	onti, Jr					ıy, Ma	artir	sburg,	Wes	st Vi	rgin	ia_25	401
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disp 1 X Burial 2		3 Removal fro		b. Place of Dis cemetery, c			e)		ate	20c.	Location -	City or To	own, State	
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Box	eath c atter	icial	in the past 12 r	months?	4 □ Pr	egnant at time	Fetal death 3 of death 5	☐ Ectop		у			100	Mon		Day	Year
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P.O.	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and attending by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	Part II. Other signifi	icant conditio)	1 -	1			en in Part	1.			use contri			
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Division	tal or s afte	ပြို		/	bui	Iding, etc. (Spe	ecify)				Į,	City or To	wn, Stat	e)			
	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Certificate:	29a. Certifier 1 (Check 2	Certifying Medical F	Physician: To the	e best of my ki	nowledge, deat	h occured	at the time,	, date and	place, and	d due to the ca	ause(s) a	and manne	r as state	d. use(s) and r	manner stated
	To the P within 2. To the F complet	Me		Certifying	Nurse Practions			e, death oc	curred at the	e time, date			ne cause	(s) and mar	nner as st	ated.	
_	₽ ₹ ₽ 8		29b. Signature and t	itte of certifier			100 000	12	9c. License	9 number	2 7		29d. D	ate signed	(Month, I	Day, Year)	
			30. Name and addre	VM _	Who completed ==	allee of dth	MD	Drint\	L	12116	-	,		710	-11		
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Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Timmons Charles Percy Physician/ Month April 2012 6:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER BERLIN NURSING AND REHABILITATION BERLIN Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 218-20-5603 Director 1 **X** M 2 □ F 85 02/25/1927 Maryland Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10b County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Maryland Wicomico Pittsville 1 Yes 2X No 10f. Zip Code 21850 10g. Citizen of What Country? Funeral 4041 Powell School Road USA I fitem 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 🙀 Married 1 Yes 2 X No 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Farming Farmer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nora Littleton Charles Prettyman Timmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4041 Powell School Rd., Pittsville, MD 21850 f Health item 27 Virginia G. Timmons/Spouse Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Powellville Cemetery: 4/28/2012 Powellville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kollp 23a. Part 1. Enter the disease, or conficient on that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 18 Immediate Cause (Final Onset and Death Physician. is Nexular sclerutiz disease or condition Medical resulting in death) Examiner 1351 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner OBI M. h. Wetes Cause (Disease or injury that initiated events burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy 1 Yes 2 No Yes Hospital or Attending Physician: 24 hours after death. **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 XDOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) April 25, 2012 613128 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print) Mary Bernal-Clark, FNP-B@715 Healthway Dr, Berlin, MD 21811 31. Date filed (Month, Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Physician NORMA CUNDIFF WILBOURNE 9,2012 MAY 8:40A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FT.WASHINGTON HOSPITAL FT. WASHINGTON If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min 8. Date of Birth (Month, Day, Year)
12-18-1931 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 □ F 8 OYrs. 230-38-1537 VA. Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Michael Exercitivar hust be notified at Director MD. CHARLES 1 ☐Yes 2 No BRYANS ROAD 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 23a or 72 hours after death with 2707 ADELPHI LANE 20616 U.S.A. Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2 □XNo Specify: Specify:WHITE <u>8</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) MUSIC DIRECTOR 12 should be filed w h and Mental Hygiei 7 is marked other th 12 METHODIST CHURCH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GRADY WILMOT CUNDIFF HELEN CATHERINE LINK traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun JOSEPH C. WILBOURNE, JR. SON 2707 ADELPHI LANE BRYANS ROAD, MD. 20616 20b. Place of Disposition (Name of Cemetery, crematory or other place)
LA PLATA METH CEM 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5-15-12 DENTSVILLE, MD. 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MONIL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, attending physician Physician/Medical the as IF FEMALE: use yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Š signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 □Yes 2 □No n 24 hours after death.

The Funeral Director: A pletely filled in by the investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

within 2

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Mi

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bonnie Lee Wyman Physician/ 29 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health and Rehab Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 1 Year 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 170-32-2817 70 **Director** 1 □ M 2**XX**F Nov. 26, 1941 ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director |Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Maryland Avenue, Apt. 10 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify: Specify: "natural" 3 Widowed 4 X Divorced Year or Dates nd Mental Hygiene.
marked other than "natur
matic event, the Medical! 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Wyman Thelma Heath or other traumatic of Page 1 and 2 show.

The page 1 and 2 show.

The page 1 and Me 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lex Winans/son 14824 Alder Creek Road Truckee, California 96161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 5/2/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran-Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò Division of Vital Records, Completed 24a. Was an autopsy performed Director: After this certificate Yes 42 L To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at work? Natural 5 Pending __ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ceftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and Atle s of person who completed cause of death (Item 23a) (Type, Print) 5 Dr. Aditya Chopra 600 Ridgely Avenue Annapolis, Maryland 31. Date filed (Month, Day,

Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 🗾 No Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) May 1, 2012

2012

U.S.A.

White

 A^{M}

7:10

Birthplace (State or Foreign Country)

Pennsylvania

10d. Inside City Limits

1XXYes 2 No

State Registrar Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James C. Waters \mathbf{P}^{M} April 7:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Berlin Nursing & Rehabilitation Center Worcester Berlin Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 Months Days Hours Min Director 217-14-9630 97 Maryland 1914 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 X No Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21863 4341 Market Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Worcester County Board Elementary/Seconday (0-12) College (1-4 or 5+) Of Education 10th School Bus Contractor Be James 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aline Truitt Hasty Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4341 Market Street - Snow Hill, Maryland 21863 Mary Waters/ Wife Waters 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer UMC Cemetery May 7, 2012 Snow Hill, MD fur of Funeral Service Licenses Salisbury, Maryland 22. Name and Address of Facility Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** oan Social fally list renellions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No. Month 5 Other (specify) Pregnant at time of death the Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed After this certificate has been s funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2 ☐ No ☐ Yes 2 👿 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **X**No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 5 Pending 2 \square No within 24 hours after death

To the Funeral Director /
completed filled in by the f Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of ertifie 29d. Date signed (Month, Day, Year) April 30, 2012 140 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins, 9715 Healthway Dr, MD, Berlin, MD 21811

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedentis Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day M AG Medical County of Death cility Name (if not institution, give street and number 4b, City, Town, or Location of Death Examiner Adu NEIGHS 5 DIta Home a 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 🔀 F Months (Month, Day, Year) 11/23/1925 213-22-9238 **Director** Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD ty Yes 2 □ No Centreville Oueen Anne 10f. Zip Code 10e. Street and Number ō 10g. Citizen of What Country? "natural", or items 23a o Funeral 104 Tilghman Avenue #106 USA 21617 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates Black 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Ith and Mental Hygien 27 is marked other the traumatic event, the 11 Manufacturing Laborer Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be innent of Health and Menta Earl JArrell Almedia Seals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Helen M. Slade 5024 Silver Hill RD Forestville, MD 20747 Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place) Direct 1 Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. ö Cremation, 5/10/2012 Dover, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Bennie Smith Funeral Home ST Dover. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ erine Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IE EEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 page certificate 1 🗆 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work Accident Suicida after death. 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner e best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of certifie 29b. Signature and Hills eath (Item 23a) (Type, Print) 4

State

and address of

** 8 2012

32. Reg

strar's Signature

a 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last 2 Date of Death Month Physician/ 2012 William Robert Wood, Jr. Mav 5:53 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 29843 Cheryl Court Mechanicsville St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 215-46-3874 1 X M 2 🗆 F 66 Yrs 07/12/1945 Maryland Usual Residence of Decedent or 28a-f show notified at 10h County 10c. City. Town or Location 10a State 10d. Inside City Limits 1 Yes 2 X No St. Mary's Mechanicsville Maryland 0 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? items 23a or ner must be n 20659 USA 29843 Cheryl Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Armed Forces? Black, White, etc. ò by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working il Hygiene. I **other than** ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farm Foreman 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I Katherine Louise Anderson William Robert Wood other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 sl of Health a If item 27 is Carol Wood / Wife 29843 Cheryl Street Mechanicsville, MD 20659 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, Brinsfield-EcholsCrem; 5/11/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols Funeral Home P.A. M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if an,, leadin, to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to lo law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Physician/Medical Box 68760 the Phy as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No ō Month Year Pregnant at time of death by the a g Unknown g Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 as autopsy perform death? certificate 2 No 1 Yes Yes Physician: B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1000 ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No death. eral Director: Ai filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of cert 29c. License number 29d. Date sig ed (Month, Day, Year) 20

State Registrar Manoj

Panwala,

Charlotte Hall

20622

MD

37767 Market Dr.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28 4 7:59 Zerr 2012 Medical 4a. Facility Name (If not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 30466 Danwood Drive Delmar Wicomico If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 □ F Min. Months Hours Country)
Maryland Director 219-30-2820 80 Usual Residence of Decedent 23a or 28a-f show ast be notified at 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No MD Wicomico Delmar 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 30466 Danwood Drive 21875 USA n "natural", or item fedical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Own Business 1 and 2 should be filed w of Health and Mental Hygi item 27 is a rarked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Thomas Zerr Lorena Stith 19a. Informant's Name/Relationship (Type, Print) and is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty H. Zerr - Wife 30466 Danwood Drive, Delmar, Maryland 21875 item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 4-30-2012 Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition ASOV) Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 ₹E FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Pregnant at time of death 5 Other (specify) Month Dav Year Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy performed Yes 2 death? 2 🗌 No 1 Tes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Tyes 2 🗆 No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 27. Manyler of Death 28a. Date of injury (Month, Day, Year) Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗂 Natural 5 Pending Accident 1 🔲 Yes 2 🗆 No Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours after To the Funeral Direc determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hu Nu 17644 4/30/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month Pey, Year)

2012

5-DIV/510N

14/5

Registrar's Signatur

MD 21804

SACISBURY

12-03429 Richard Dale Albus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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130		1- For State Registrar	С	ertificate of	Death		Reg	j. No.				
Physicia Medical Examir	n/	Decedent's Name (First, Middle Control of Control	Dale Al	bus			May 3, 2012		3. Time of Death 1605 hrs			
		4a. Facility Name (if not institution 1013 Dumbarton Road	•		b. City, Town, or L Glen Burnie	ocation of Deat		4c. County of De	del			
Funeral Director		5. Social Security Number 236.78.6097	6. Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr Hours Mir	s. 8. Date of Birth	_ 100	Birthplace (State or WV reign Country)			
Maryland 28a-f show any d at once.	tor	Usual Residence of Decedent 10a. State 10b. County Anne	Arunde 100.0	ity, Town or Location	urnie				10d. Inside City Limits 1 Yes 2			
th the Mary 23a or 28a	Il Director	10e. Street and Number	barton		10f. Zip Code	60	, 10g	g. Citizen of What C	Country?			
ifter death wi	y Funeral	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Dive	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No orced If Yes, Give Yeer, or Dates:	If Ye	S Decedent of Hisp es, specify Cuban, Yes 2 No	Mexican, Puerte		14. Race - An White, etc	nerican Indian, Black,			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 in marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Spec Elementary/Secondary (0-12)	ify only highest grade completed) College (1-4 or 5+)	16a. Decedent during mo	's Usual Occupation of working life. [ired)	16b. Kind of Busine	ss/Industry			
1215-0036 be filed within 7 nital Hygiene. rrked other than vent, the Medica	Be	17. Father's Name (First, Middle,	unk	J F IE.		unk	e (First, Middle, Ma	unk.	▼			
e, MD 2121 and 2 should be f Health and Mental item 27 is marked	٩	19a. Informant's Name/Relationsh	el Friend	19b. Mailing	-eymax	Rd.	Glen	er, City or Town, St	MD 21060			
MOFE Pages 1 hent of H nut: If i		_	3 Removal from State	crematory or oth		1- Ma	4172012	Betsil	le MD			
Balti permit. Departm Imports injury o		23a. Part AEnter the disease, or	complications that caused the dea	B 187	17 Green	~ Past	or respiratory arrest	Balto	1021286 Approximate Interval			
/Medical xaminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive Atheros Due to (or as a consequence		ovascular Dise	ase			Between Onset and Death			
	iner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a consequence	of):								
	I Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.	of):								
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A 44 50 A	Physician/	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkt	4 Pregnant at time of	death	al death 3 er (Specify)	Ectopic pregna	ancy	Month	Day Year			
P.O. es that the igned by detach	2	Part II. Other significant condition History of colon cance		t resulting in the un	derlying cause giv	en in Part I.			to the cause of death?			
Division of Vital Records, tal or Attending Physician: The law requires after death. In Director: After this certificate has been in the funeral director, page 2 should be in the funeral director, page 2 should be in the funeral director.	Completed						24a. Was an autopsy performe	prior t ed? death				
tal Re-	S S	25. Was case referred to medical examiner?				Death (Check						
n of Vital Recting Physician: The I	의.	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient 28b. Time of In			ng Home 5 Re	esidence 6 🗸 Otl	her: Scene			
Sion of Attending Pt r death.	Certification:	1 Natural 5 Pendi	(Month, Day,Year) ng igation		1☐ Ye	s 2 No			Dural Durah Number Offi			
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To the Howithin 24 h To the Fun completely	edica	(Check only Certifying Ph	iner: On the best of my knowle iner: On the basis of examination and manner stated.			eath occurred a	at the time, date and		the cause(s)			
	-	D-2)			O.C.M.			May 4, 2012	way, rour/			
\va		30. Name and address of person v Donna M. Vincenti, MD	Assistant Medical Exa	miner 900 V	V. Baltimore S	treet, Baltin	nore, MD 2122	23				
Sta Registr	te ^s ar	31. Date filed (Month Doy Year)	32. Registrar's Signa	ature Colonia								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John Richard Anderson Sr. 11:22 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ROSE dale 4c. County of Death
Baltimore County of Death **Examiner** HOSPITA uare dal 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Months Min 213-42-4876 71 Director 1 X M 2 □ F ΜD 01/17/1941 ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 Funeral 807 Mace Ave USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Tyes 2 No If Yes, Give 1963-66 Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: "natural", 3 🕅 Widowed 4 □ Divorced Completed John Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. Packaging Machinist 10yrs Be 18. Mother's Name (First, Middle, Maiden Surname) Sophia Wendt 17. Father's Name (First, Middle, Last) Charles Wayne Anderson 19a. Informant's Name/Relationship (Type, Print) Daughter Donna M. Steger 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crem 20a, Method of Disposition 20c. Location - City or Town, State Date . Page 1 1 Burial 2 XCremation 3 Removal from State 05/14/12 Glen Burnie MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD noms 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Due to (or as a consequence of) 010 disease or condition resulting in death) Medical Examiner anic My Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequenceard ae the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy this certificate has 1 Yes 2 No 25. Was case referred to medica Division of Vital 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manher of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 V Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Aft eletely filled in by the fur Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier mpletely. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 5806 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Jonah Douglas 4:07AM Barr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner BAltimore OSCDAle VAre HOSPITAL 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 179, Ye Hours 1**X** M 2 □ F 10 MaryTand 2012 Director Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Maryland Baltimore Sparrows Piont 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21219 U.S.A. 3001 Ross Avenue , or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2XXNo BAFF, JONAH Δ . Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: 3 🗆 Widowed 4 🗆 Divorced "natural" Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 0 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brown Julia Carolyn Brandon Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3001 Ross Avenue, Baltimore, Maryland 21219 Julia Brown (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 05/18/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 gnature of Fundal Scrum Licensee 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Kremature Rupture of Membrances At 16 WK Squstation disease or condition Medical resulting in death) Que to (or as a consequence of) **Examiner** TU Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending physical for use as the b IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ The law requires Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 🗌 Yes 2 🗷 No certificate Yes 2 X No Hospital or Attending Physician: **Division of Vital** director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 은 1 Maligner 1 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square DrivE BAltimore, MD 21237 Tran MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

			for Amend State Registrar	Item	State of M 23a PtII	arylan per	d/Depa me,g92 Cer	rtme tifica	nt of 177 te of L	lealth 2012 Death	and N	Mental Hy	giene Reg. No.	201	2	15	807
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	Physicia Medic		ROSE R			BU	RKOM					MAY	14,	2012		11:05	РМ
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ary	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Rela	tionship (Typ	e, Print)			ng Addre	ss (Street a		-	al Route Numbe	r, City or T	Town, State,			
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	Sta Registr		MAY 1					1.1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Amend Items 23a PtI,25 per me 2927 05/17/2012dhb Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month 4:40 PM Charles Blevins Sr. May 2012 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Agnes Hospital Baltimore, Masyland If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Min (Month, Day, Year) Director 218-40-1594 1 X M 2 🗆 F 03 68 24 44 A L 3a or 28a-f show be notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Pikesville MD 10e. Street and Numbe 10g. Citizen of What Country? items 23a Funeral must l 4712 Old Court Road 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 0 by 1 Never Married 2X Married 1 SyYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 Tes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Black Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Veterans Health d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 3yrs Housekeeping Aid Care System should be filed v and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie J. Blevins Sr. Ethel Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trat onc e. 4712 Old Court Road, Pikesville, Md 21208 Marie Z. Blevins-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 5/18/2012 Owings Mills, Md Signature of Juneral Service Licens 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one ca e on each line. Intracranial hemorrhage Immediate Cause (Final Physician/ Choorde disease or condition tweek Medical resulting in death) Due to (or as a Thrombocytopenia Examiner aments, Mclastate Prosta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CEPTIFICATION APPROVIED BY MEDICAL EXAMINATION Examine Chemotherapy Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Metastatic Prostate Cancer that the death certificate be Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Unknown Yes 2 No be detached 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of Jas page 2 autopsy performed' death? certificate 2 🗌 No 2 - No Yes of Vital Physician: funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work?
1 Yes 2 No Natural 5 Pending Belinns Division Investigation Accident after death completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To th. within 24. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Medical resident PGYZ P25483 May, 09,2012 St. Agner Hospital, 900s Caten Avenue, Baltimere, Masyland 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priyas Visusanathan

Registrar DHMH 17 Rev 06-2011

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Date filed (Me

2012

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Siranush Bayatyan May 2012 7:35 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death North Potomac 12435 Falconbridge Drive Montgomery 8. Date of Birth (Month, Day, Yea Nov • 29, Social Security Number If Under Year If Under 24 Hrs. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Russia Months Hours Min WIL 84 Director Usual Residence of Decedent 28a-f show with the Maryland 10a, State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 X No Montgomery North Potomac ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 12435 Falconbridge Drive 20878 Armenia within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. White "natural", Completed 3 X Widowed 4 □ Divorced Specify Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Business Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arshak Bayatyan (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 12435 Falconbridge Dr., North Potomac, MD Valeri Akopov / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 05/17/2012 Beltsville, MD 21. Signature of Fun (ral) em. Licensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring,MD 20 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ BREAST CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) **To the Hospital or Attending Physician:** The law requires that the death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ding physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 XX Residence 6 Other (Specify) 2 🗶 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 🗌 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) D29625 MAY 15, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RALPH V. BOCCIA M.D., 6420 ROCKLEDGE DR. #4100, BETHESDA, MD 20817 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 5810 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Cheryl Bryan 6:30A M MAY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Season's Hospice Randallstown **Baltimore** If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Oct 6,1949 Maryland 218-80-3298 Director 1 🗆 M 2 🗓 F 62 shov 10h Counts 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director notified MD 28a-f Baltimore Gwynn Oak 1 Yes 2 No 10g. Citizen of What Country? 9 10e. Street and Numbe 10f. Zip Code ms 23a or must be r Funeral 26 Cedar Heights Court 21207 Apt A USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXVo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ural", or item 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify White Specify. "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clothing 9 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Marlene Rauchhaus Herbert Leroy Kaufman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Linda Harlow (Sister) 6608 Harrison Avenue Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) _2 X Cremation 3 ☐ Removal from State 1 Rurial Atlantic Crematory : 5-17-2012 4 Dopatio 5 Other (Specify) Glen Burnie, MD 21. Signati 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 Approxi 23a. Part 1. Enter the disease, or complications that caus shock, or head failure. List only one cause on each Interval Between Breast Cancer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months
1 Yes 2 No Pregnant at time of death Month Day Year ed by the at detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 performed? Yes 2 No 1 Ves funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home } 5 \(\text{Residence } 6 \(\text{Other (Specify)} \) 1 ☐ Yes 2 🛮 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the l only one) 29c. License number 29d. Date signed (Month, Day, Year) ns RajapatheMD 00057465 5/11/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAMPHKHMD 2835 Smith /IV S 7 03 Baltimore MO 21209

31. Date filed (Month, Day, Year,

51aic Replaire DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:39 PM Margaret J. Bloodsworth May 3, 2012 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1109 S. Schumaker Drive #310 Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🕅 F 88 Mar 22, 1924 216-18-2600 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show MD Wicomico 1 ☐ Yes 21 No Salisbury other traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number or items 23a or 1109 S. Schumaker Drive #310 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: white à 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within than Elementary/Secondary (0-12) College (1-4or 5+) teacher education and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Woolford Jones Maddie Brittingham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any Injury or other tra Health a John E. Bloodsworth/son P.O. Box 2392 Salisbury, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Use Ronald 22. Name and Address of Facility Made State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, other failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** Metastat 12 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 5 Pending investigation Injury 1 Natural 1 □Yes 2 □No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlansit completely filled in by the funeral director, page 2 should be detached for use as the burlan-transit Box 68760, P.O. Records, Division of Vital

aryland 21215-0036

Baltimore,

State

29b. Signature and title of certifie

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Typg, Print)

29c. License number

29d. Date signed (Month, Day, Year)

3 Saluly MD 21802

K

DHMH 17 Rev 1/2001

State Registrar 8813 Waltham woods Rd

Parkville,

MD-21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bha ray

Bhavneer

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Daisi H. Cottrell 2.20 al 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Locatio City, Town, or Location of Death 4c. County of Dea Examiner SINAI HOSPITAL an NIA BALTIMURE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Director 1 M 2 XF 1916 08 Hygiene, other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1429 N. Dukeland Street 21216 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Builders Stager Martex 12th grade Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name First, Middle, Last) LDUIS Blackwell laylor 19a_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Buth Bellam 16 Cataloa Court Baltimore MD 212091 (Danahter 20b. Place of Disposition (Name of cemetery, crematory or other place)
KINA MEMORIAL Par 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date 05 25 2012 Winder Mill, MD Memorial Park 22. Name and Address of Facility Vaugn C. Greene Funcial Services 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart ailure. List only one cause on each line. Interval Between Onset and Death SEPSIS Immediate Cause Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner DAYS . NEGATIVE BACTEREMA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) nding physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION OSTEDARTHRITIS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No FIBRILLATION, CACIC 24a. Was an cate has by page 2 s autopsy performed To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 X npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After I completely filled in by the funer 1 Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 MAY-16. 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital Battimore Isanavali 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 1 8 2012 Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 29d, per phy, g927 5-18-12 sm State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year 10 Physician/ A M 2012 WILLIAM W. CWIEK Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rosedale Baltimore FRANKLIN SQUARE HOSPITal 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Months Days Hours Min (Month, Day, Year) Director 218-28-4552 1 XM 2 🗆 F 81 6-28-1930 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTO. PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? pe r tems 23a Funeral with must USA 8800 WALTHER BLVD. APT.3601 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 0 by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify "natural" Completed 3 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event; the Man once. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 DENTIST DENTAC 12 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BERTHA JEROMIN FRANK CWIEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUZANNE CWIEK **SPOUSE** 8800 WALTHER BLVD. APT.3601 PARKVILLE, MD 21234 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State ATLANTIC CREMATORY 5-10-2012 GLEN BURNIE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERALHOME, INC. Signature of Funeral Service Licensee 6415 BELAIR ROAD BALTO.MD. 21206 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Heart Failure Concestive

Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner neumonia Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Renal Acute Due to (or as a consequence of) resulting in death) Last Physician/Medical Disease oronary Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? ģ Month Dav Year Pregnant at time of death Unknown the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician; 25. Was case referred to medica **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) DO011912 HOSPITALIS T 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR Balto Md 21237 Sheenu Sheela 4000 31. Date filed (Month, Day, Year) 32. Registra's Signature State 1 8 2012 Registrar

Willia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14, 2012 May 7:15 P M Marie V. Collins Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Funeral Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 236-26-1781 1 M 2 X F 89 Oct 2, 1922 West Virginia Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Hyattsville Prince George's MD 10e. Street and Numbe 10g. Citizen of What Country? Funeral United States 2012 Rittenhouse Street 20782 an "natural", or items Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify Completed 3 XWidowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Restaurant Waitress other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o မ be (unk) Alice .. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke John Howel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2012 Rittenhouse St. Hyattsville, MD 20782 Shirley Specht / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State or Department of Important: If any injury or once. Journey Crematory 5/17/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Final Sing ure of Funeral Service Live see Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Syndrome (Advanced) Myelodysplastic disease or condition Examiner Medical resulting in death) Neutro enic Fever Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sepsis Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Director: After this certificate 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ျပ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending work' 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direc determined

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and title of c

31. Date filed (Month,

3

Anisha Kumar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Rd.

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D73240

Silver Spring, MD 20910

May 15, 2012

29c. License number

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 07:20 pm 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Town, or Location of Death 4c. County of Death Ltimore **Funeral** 6. Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Country) Director 1 M 2 M or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian. Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry fe. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WARD 19a. Informant's Name/Relationship (Type, permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 5 Other (Specify) 4 Donation 23a. Part 1. Enforthedisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Atherosclerotic Cardiovascular disease 1KNOW1 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or se's nonesquence of) the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ should be detached for Pregnant at time of death g Unknown JUNAN TR g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an death? ☐ Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Investigation 1 Yes 2 No ompletely filled in by the I Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 D0058141 may mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900. S. caton Wendie Williams MD Avenue Balt. more, MD 21229

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2310 Baby Boy Christian Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The 14. a MOVO 8. Date of Birth (Month, Day, Year) May 5, 2012 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Months Days 1 🛛 M 2 🗆 F infant Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 □ No MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5002 Castle Stone Drive Funeral 21237 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 X Never Married 2 ☐ Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: black "natural", Completed 3 Divorced 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nr
any injury or other traumatic event it. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Theresa Christian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) The Johns Hopkins Hospital 1800 Orleans Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state 21. Sign the of Funeral Service Licensee 22. Name and Address of Facility Direcroe State Anatomy Board Baltimore, MD 21201 655 W. Baltiore Street . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Extreme Prematurit √Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death signed by the aid be detached t 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Yes 2 No 3 Probably 4 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 certificate 1 Yes 2 No 1 Yes Division of Vital 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 No 1 Tes ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 3 🗆 29b. Signature and title of certifier 29c. License number

State Registrar 1800 Or leans St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin	er						r Location of Death	1	4c. County Balt		•		
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	or 28	Ö	Maryland Balt 10e. Street and Number	THIOLE	Ess	ex	10f. Zip Code			10g. Citizen of	What Cour			
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	death item ner m		11. Marital Status	12. Was Decedent Armed Forces			Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		ce - Americ			
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ M 3 ☐ Widowed 4 X Divorce	If Yes, Give	Ž No		☐ Yes 2X No		,		Whit			
9	within 72 hours after death with the Maryland igiene. In than "natural", or items 23a or 28a-f sho is, the Medical Examiner must be notified at	Completed	15. Dece	dent's Education		16a. Deced	lent's Usual Occup	ation		16b. Kind of B				
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E O	Page nent o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other	on 3 ☐ Removal from Stat r (Specify)			natory or other place crematory	· 5/	13	Baltim	ore.	Marvla	nd	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Servic	e Licensee	1									
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Division of Vital	il or Attencater death after death Director: , d in by the	Certificate:	3 Suicide 6 Cou 4 Homicide dete	rmined 28e. Place of In	njury - At ho etc. (Spe <i>cify</i>)		et, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural	Route Numbe	er,	
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	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending ple completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	ledical	(Check 2 \(\sum \) Medica	ing Physician: To the best of al Examiner: On the basis of ing Nurse Practitioner: To t	examination	and/or invest	igation, in my opinio	on, death occurred a	at the time, date a	nd place, and du	e to the cau	ise(s) and man	ner stated.	
	To the To the Comp	Σ	29b. Signature and title of certif		ino Bost of II	iy kilowicage,	29c. License			29d. Date signe				
			Countles	Jonnen	MI	0	0002	13811		05/1	7/1	2		
	10		30, Name and address of person	on who completed cause of	death (Item	23a) (Type, P	rint) + C	(10n ·	0 11	' A'	. 1/1	0		
	W	2.0	JONATHAN . F	orman M			interfie	WEN ST	ett 41	envorn	14 [1	1) 2 100	1	
	Stat Registra		31. Date filed (Month, Day, Year	8 2012 Bus	un o digital	D. A	arke		-					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ MACY 16 Day 2012 a 1:00A M Louise Marv Derr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min Months 218-38-2500 **Director** 73 1 M 2 X F 3/1/1939 Maryland show 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 🗆 Yes 2 ื No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 222 Deerfox Lane 21093 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗶 No Specify: "natural". Specify: White Completed 3 Widowed 4 Divorced other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) Volunteer Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ပ Frank A. Gunther Frances Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>George F. Derr, III / Husband</u> Deerfox Lane Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place. Hilltop Service Corp. 5/17/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 6 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician Medical P.O. Box 68760 the as attending properties as IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death g Unknown g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ MULTIPLE MYELOMA Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown PANCYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate END STAGE RENAL DISEASE 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, D37254 16 5

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM, M.D. 7601 OSLER DRIVE TOWSON, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Maryland		artment of H		d Menta		0	012	15021	
			Registrar 1. Decedent's Name (First, Middle, Last)		- 007	uncate of D	cairi	2. Da	te of Death	j. No.	U14	3. Time of Death	
	Physicia Medic		Richard Farrell	Davis				Mo	onth 5	Day / Y	2012	1825 M	
	Examin		4a. Facility Name (if not institution, give street and n	,		4b. City, Town, or	Location of De	ath		4c. Count	ty of Death		
	<i>;</i>			ial Center		Baltimo							
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		te of Birth 0.0311	857	g. Birthpl	ace (State or Foreign Cornia	
			563-46-8016 Usual Residence of Decedent	/4				1 07	/ U3/ I	937	T Call.	LOLISTA	
	land f sho	tor	10a. State 10b. County	10c. City, **	Town or Lo	cation					10	d. Inside City Limits	
	Mary 28a-1 otifie	Director	MD Cecil	Por	t Dep							1 🗌 Yes 2 🔀 No	
	th the 3a or the r	ral	10e. Street and Number			10f. Zip Code					f What Count	ry?	
	ath w	Funeral	1776 Jacob Tome Highwa	y ecedent Ever in U.S.	13 V	21904 Vas Decedent of His	spanic Origin?	(Specify Ye		U.S.A	ece - America	n Indian	
9	or ite	by F	Armed 1 ☐ Never Married 2 🔀 Married 1 🔁 Ye	Forces?	l1	Yes, specify Cubar	, Mexican, Pu	erto Rican,	etc.)		ack, White, e		
933	urs aff ural", Il Exa	ted	3 ☐ Widowed 4 ☐ Divorced If Year or		_ 1	Yes 2 No	Specify:			Specif	fy: W	Mite	
15-(72 hou	Completed	15. Decedent's Education (Specify only highest grade complete	ed)	(Give F	ent's Usual Occupa aind of work done du		vorking	16	6b. Kind of I	Business Indi	ustry	
12	ithin iene.	Cou	Elementary/Seconday (0-12) College	(1-4 or 5+)		on Worker				Con	struct	ion	
p	iled w Il Hygi othe rent,	Be	17. Father's Name (First, Middle, Last)		110		18. Mother's N	Name (First,	Middle, Mai			,	
/lar	d be f Menta arked artic ev	욘	Charles E. Davis				Mary	Ε.	You	ng			
lan	shoul and I is ma		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	nd Number or	Rural Route	Number, Ci	ty or Town,	State, Zip Co	ode)	
≥,	and 2 fealth em 27 her tr		Helga I. Davis / Spou			Jacob To	me High						
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	om State cen	netery, crem	sition (Name of natory or other place		Date			1 - City or Tov		
計	nit. Pa artmei ortani injury		4 ₭ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Li Insee	Anato		ts Registry Name and Address		/18/20			r, Mar		
Ba	permi Depar Impor any ir	, ,	21. Signature of unional Service Entrisee	-		522 Conne							
T			23a. Part 1. Enter the disease or complications the	at caused the death.					-			Approximate	
	Pnysician/	1	shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition	4	co	when the	file	~				Interval Between Onset and Death	
	Medical Examiner		resulting in death) a. Due 1	o as a consequer	ice of):	piratory	-, 4, 10,	, e					
		r l	Sequentially list conditions, b.	toute Re	spirati	ory Dist	ress S	yndro	me		2	2 weeks	
	pe tisi	mine	dram, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	+ cute Re-	ee utji		١ . ١	1:00			3 weeks		
N	xecut	Еха	that initiated events c. Due to Due t	o (or as a consequer	ice of):	nterstitis	·\ IVng	dise	ase_			weeks	
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	d										
Box 68760	requires that the death certificat been signed by the attending ph should be detached for use as th	Mec	IF FEMALE:							1			
9 ×	th cer ttendi or use	ian/	23b. Was decedent pregnant 23c. If yes, of 1 Lin Lin	outcome of pregnance re Birth 2 Fetal d	leath 3 🗌	Ectopic pregnancy					ate of deliver	y Day Year	
Bo	the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pr g ☐ Unknown 9 ☐ Ur	egnant at time of dea nknown	ıth 5∟	Other (specify)				IV	IOTILIT L	Day rear	
P.O.	hat th ed by detac	by Ph	Part II. Other significant conditions contributing to		ing in the u	nderlying cause give	en in Part I.	23	Be. Did tobac	co use cor	ntribute to the	cause of death?	
<u>8</u>	uires t n sign ald be	q pa	Asbestos exposure	-				_	1 🗆 Yes	2 No	3 🗌 Proba	ably 4 🗆 Unknown	
Division of Vital Records,	w req	Completed	Asbestos exposure Aortic Valve replace	ement				24	1a. Was an	24b		sy findings available	
Rec	Physician: The law ir this certificate has beral director, page 2 s	Com						_	autopsy performe Yes 2	d? No	death?		
<u> </u>	ctor,	Be	25. Was case referred to medical examiner?				ce of Death (C						
Ž	Physic this or al dire	유	1 Yes 2 No	Inpatient 2 EF			4 ☐ Nursing				her (Specify)		
0 0	ding f h. After funer	Certificate:	1 Natural 5 Pending	te of injury 28 onth, Day, Year)	Bb. Time of injury	28c. Injury work? M1 \bullet		28d. De	escribe how	injury occur	rred		
Sio	Atten r deat ctor; y the	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	ce of Injury - At home	e, farm, stre		les Z 🗆 NO	28f. Lo	cation (Stree	et and Numi	ber or Rural F	Route Number,	
Σ	s afte		4 ☐ Homicide determined bui	ding, etc. (Specify)					y or Town, S				
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director, After thi completed filled in by the funeral varieties.	Medical	29a. Certifier (Check 2 Medical Examiner: On the	best of my knowled	ge, death o	ccured at the time,	date and place	e, and due to	o the cause(s) and man	ner as stated		
	the P the F the F mplet	Me	only one) 3 Certifying Nurse Practione 29b. Signature and title of certifier			eath occurred at the	time, date and		due to the car	use(s) and n	nanner as stat	ted.	
	5 ± ₹ 5		29b. Signature and title of certifier MD			29c. License		27.7	- 1	1	ed (Month, Da /	ay, Year)	
	d		30 Name and address of person who completed as	use of death (Item 20	Ra) (Type P	rint)	5958°			3/14/	2012		
	Ψ		Donald Harris, MD	22 S. Gre	ene	Street.	Baltim	ore. N	ND 2	21201			
	Stat	٠.	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	11								
	Registra	ir	MAY 1 8 2012 Denus	p. ga									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 13,2012 LAURETTA CATHERINE DONNELLY 1:59P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6519 BELLE VISTA BALTIMORE Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 220-36-3020 Director 1 □ M 2 F 71 9-2-1940 MARYLAND Usual Residence of Deceder 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6519 BELLE VISTA AVENUE 21206 IISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X Black, White, 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Sec 12TH condary (0-12) College (1-4 or 5+) HOMEMAKER HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 0 ALBERT ST. JEAN MABEL CLOCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 BRIAN DONNELLY SON 6519 BELLE VISTA AVENUE BALTO.MD. 21206 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State MOST HOLY REDEEMER 5-17-2012 BALTO.MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Distamp 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ cancer disease or condition Medical resulting in death) **Examiner** ta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence on burial-tran Due to (or as a consequence of) attending physiciar Physician/Medical 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Dav Year 5 Other (specify) signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 🗌 Yes Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : has autopsy performed? funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 Residence 6 \square Other (Specify) 1 ☐ Yes 2,☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 the only one) 29b. Signature and title of certifier 20 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 East 33rd st. Suite 460, Baltimore MD

Registrar
DHMH 17 Rev 06-2011

State

MAY 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State	State of Ma	ryland / Depa	rtment of He tificate of De			71	12	15823	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	incate of De	caur	2. Date of Dear	seg. No.		3. Time of Death	
P	hysicia Medic		Mary Catherine E	rnst				Month May	$1^{D_4^{y}}$, 2	2012	4:35 PM	
7. 4	Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or L			4c. County			
-			12703 Chilton Circ		(In yrs. last birthday)		Spring If Under 24 Hrs.	8. Date of Birth	ry lace (State or Foreign			
	uneral rector			M 2 XF	Yrs. last birtilday)	Months Days	Hours Min.	(Month, Day,	Year)	Country)		
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ryland	-f sho	ctor	10a. State 10b. County		10c. City, Town or Loc		Q			110	0d. Inside City Limits 1 Yes 2 XNo	
е Ма	or 28a	트 e	MD Montgor 10e. Street and Number	nery		Silver 10f. Zip Code	Spring		10g. Citizen of	What Count		
with t	23a	Funeral Director	12703 Chilton Circ	cle		209	04		Unite	d Sta	tes	
13-UU36 72 hours after death with the Maryland	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13. V	/as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America		
after o	ıl", or xamit	db	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	0	☐ Yes 2 X No			Specify			
Z1 5-0036 in 72 hours after e.	atura ical E	Completed	15. Decedent's Ed		16a. Deced	ent's Usual Occupat	tion	.	16b. Kind of B			
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yland yland lid be filed Mental Hy	ked o	10 E	John Joseph Lead	777			Henriet	_	rews	3)		
Dinould Me	is marked or aumatic ever		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street an			0.47	State, Zip C	ode)	
, Mar nd 2 shou saith and	n 27 i er tra		Catherine Ernst	/ Daughter	1930	Ocean Av	<i>r</i> e #314 S	Santa Mo	nica, C	A 904	05	
Ore Pelar tofHe	If iter or oth	П	20a. Method of Disposition 1 □ Burial 2 🎛 Cremation 3 □	Removal from State		atory or other place,)	Date	20c. Location			
Saltimore, permit. Page 1 and Department of He	rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service / □ nse		inal Journ						Maryland	
Depart	Important: If item 27 is marked any injury or other traumatic ev once.	- 7	Swules A H	Rehut	MO1251 B	ing Home everly L.	Crematic Heckrott	on Servi ce, P.A.	ce P.O. Clarks	Box ville	784 MD 21029	
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certific	inding use a	M/m	23b. Was decedent pregnant	3c. If yes, outcome o	f pregnancy	Ectonic pregnancy	,		23d. Da	ate of delive	ery	
Geath c	ed for	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant at		Other (specify)			Me	onth	Day Year	
that the	d by the	Phy	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use conf	ribute to th	ne cause of death?	
S, T	signe Id be	d b	Hypertension					1 🗆 1	yes 2 🔀 No	3 Prob	oably 4 🗆 Unknown	
DIVISION OT VITAI RECORDS, P.O. tal or Attending Physician: The law requires that the rs after death.	s been	olete	Non-specific Alco	hol Abuse				24a. Was a		Were autop	psy findings available mpletion of cause of	
He la	ate ha	mo	•					perfor	rmed?	death? 1 Yes		
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r VI	this o	년 ::	1 ☐ Yes 2 🔀 No	1 Inpatie	nt 2 ER/Outpatier	other	4 L Nursing Ho	ome 5 🛂 Resid 28d, Describe h)	
on on one of the one	: After e fune	cate	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year) injury	work?		200, 2000, 120 11	or injury occur.			
/ISIC r Atter	rector by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Hornicide determined	28e. Place of Injur	y - At home, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numb	er or Rural	Route Number,	
DI pital o	eral Di	1	A Markita a River				data and along o	and due to the or	was(s) and man	nor an atat	ad a	
e Hosi	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Examir only one) 3 Certifying Nurs	er: On the basis of ex	amination and/or inves	igation, in my opinior	n, death occurred a	t the time, date a	nd place, and du	e to the cau	use(s) and manner stated.	
To the	To the	2	29b. Signature and little of certifier			29c. License		$\overline{}$	29d. Date signe			
					NO MY	D62	590		May 16	5, 20	12	
5	V		30. Name and address of person who wendy Wong 2101		ath (Item 23a) (Type, F ark Dr. S.		ing MD	20902				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar				20002				
	Registr	ar	MAY 182	012 2000	~ A. A	are						

awrence Edward E		Sta	te of Marylan	id / Depart	ment of ficate of	Health and	d Menta	al Hygiene	Reg. N	2 (012	158
Physician/ Medical Examiner	1. Decedent's Name Lawrence		Last) rd Eckert					2. Date of Month	f Death			ime of Death
		Park Driv		ber) . Age (In yrs. last		b. City, Town, or Ellicott City		Death		4c. County of I Howard M/DD/YYYY)		ce (State or unk
Director	Usual Residence of		1 X M 2 F	6		Months Days		Min	7, 1		Country	
5-0036 led within 72 hours after death with the Maryland stygiene. after than "natural", ur items 23a ar 28a-f shnw any the Medical Examiner must be notified at nace. Completed by Funeral Director	10a. State MD 10e. Street and Num 9801 Gwy 11. Marital Status 1 Never Marrie 3 Widowed	Howar hber nn Par d 2 Ma 4 Divo	k Drive	E11 dent Ever in U.S. ces? 2 X No	1 1 1 6a. Deceden	City 10f. Zip Code	specify:	Puerto Rican, et	or No-	14. Race - Mhate White, 6 Specify: D. Kind of Busin	1 t Country? American etc.	Indian, Black,
21215-0036 ould be filed within 72 hour ould be filed within 72 hour d Mental Hygiene. s marked after than "natu tic event, the Medical Exar To Be Completed					19b. Mailing	unk Address (Stree		Name (First, M			State, Zip	unl Code)
Baltimore, MD 3 permit. Pages I and 2 shou Department of Health and Important: If item 27 is injury or other traumatte	O.C.M.E 20a. Method of Disp 1 Burial 2 4 Donation 5 21. Signature of Full	oosition Cremation X Other Sp	3 Removal from	m State cre	ace of Disposematory or oth	W. Balta ition (Name of ce her place) ame and Addres State An	metery,	Date		c. Location - C		
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Records, P.O. In The law requires that the ficate has been signed by the page 2 should be detached.		ficant condit	ions contributing to	death but not res	sulting in the			1 24:	Yes 2	2 No 3 24b. W pr	Probabl	cause of death? y 4 Unknown sy findings available pletion of cause of 2 No
n of Vital ling Physician: After this certifuneral director on: To Be	25. Was case refere examiner? 1 Yes 27. Manner of Dear	2 No th 5 Pen Inve	Hospital: 1 Ir In In Ir In In Ir In In Ir In Ir In Ir In In Ir In I	of Injury Day,Year)		DOA Injury 28c. Inj	Other ₄ ury at Work	No Subject	5 Reescribe how	sidence 6 vinjury occurred based on Coloret and Number e)	ed ocaine er or Rural	Route Number, City
Division To the Hospital or Attend within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	29b. Signature and	Certifying P Medical Exa	hysician: To the besiminer: On the basis of and manner ster	t of my knowledg of examination an tated.	e, death occu	29c. Licer	date and pla on, death oc nse number	ice, and due to t	the cause(s	s) and manner	as stated. ue to the c	ause(s)
Stat Registra	Ana Rubio a 31. Date filed (Mor	MD. As	sistant Medical E		00 W. Bal	timore Street	, Baltimo	ore, MD 2122	23			
DHMH 17 Rev 1/200	1		CME	/	ORIGIN	AL						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day2 Physician/ 2012 Myth 3:58 P M Richard William Eyring Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Min. Country) 212-36-6394 Director 1 😾 M 2 🗆 F 16, 1938 Maryland 73 Yrs. Dec. Usual Residence of Deceden 28e-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r then "neturel", or Items 23e or 28e-f sho the Medical Examiner roust be notified at Director WX Yes 2 □ No Baltimore City Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21223 United States 941 South Brunswick St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black White, etc. \$ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21√XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 al Hygiene, Elementary/Secondary (0-12) College (1-4 or 5+) Master Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be flieven and Mental H 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pege 1 end 2 sho Depertment of Heelth en Importent: If Item 27 Is eny Injury or other treu once. 8080 Armiger Dr., Pasadena, Maryland 21122 Chaney/ Daughter-in-law Kelly 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Crownsville Veterans
Cemetery 1 Deurial 2 Cremation 3 Removal from State May 18,2012 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. achate. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner WILL Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Hospitel or Attending Physicien: The lew requires that the deeth certificete be executed 24 hours efter deeth. use es the buriel-tren that initiated events Due to (or as a consequence of): resulting in death) Last the ettending physicien thed for use es the burlei Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) be deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Hospitel or Attending Physicien: The iew requires within 24 hours effect deeth.

To the Funate Director After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Residence} \) 6 \(\text{\text{\text{Other}}} \) (Specify) 1 ☐ Yes 2 ☐ 1√10 မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 71011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MAY 1 8 20

N

32, Registrar's Signature

RAUIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edemekong Esema 10:58 PM MAV 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or cation of Death 4c. County of Death AGNES BALTIMORE HOSPITAL N/A Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Year Months Director 1 □ M 2**X** F 57 06/06/1954 Nigeria 28a-f show 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director Centerville MD Fairfax Co. 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 5475 Middleborne Lane 20120 U.S.A. within 72 hours after death 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: Black Completed 3 Widowed 4 Divorced er than "natur the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the r traumatic event, the 5+ vears Nurse Alexandria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 and 2 should be Health and Ment Joseph Esema Ekanem Itata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Ibok Esema(brother) 1526 Clairidge Rd., Gwynn Oak, MD 21207 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of J. D. Esematory or other place) 20c. Location - City or Town, State of l 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Compound 05/22/12 Akwa, Ibam State Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hemorr hagic disease or condition UNKNOWN Medical resulting in death) Due to (or as a consequence of) Examiner UNKNOWN Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant Box 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Liver Concer 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes XX No 2 \square No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours 8

To the Funeral D 29a. Certifier 🛂 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. direct committed at the time, date and place, and due to the cause(e) and manner as stated Signature and title of certifier 29c. License number 070118 7 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DARK 900 SOUTH CHTON CEDRIC AUENLE: MD 21229 BALTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month/ **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Tyear If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Age (In **Funeral** Days Hours 214.48.7064 Director Usual Residence of Decedent the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "netural; or flems 23a or 28e-f show ury or other traumatic event, I'm Mexical Exuritment must be notified. 1 ☐ Yes 2 ☑ No Completed by Funeral Director lameron 10g. Citizen of What Country? 10f. Zip Code USA 20628 Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No 1 Tyes f Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) Elementary ransportation 3. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19b. Mailing Address (Street and Numb or Town, State, Zip Code) 20b. Place of Disposition cemetery, crematory ameron, MD 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. ☐ Burial 2 Cremation Baltimore 3 Removal from State reen ^ 4 □ Donation 5 □ Other (Specify) 22 Vagan Hodress @ Fac@reene Funeral Servi ces 21. Signature of Funeral Service Licens 5151 Bulto. Nat'l Pike (plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Shock /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed lon and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 4 Donknown 3 Probably 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2: autopsy certificate 2 No 2 No 1 Tyes 1 Yes Be 25. Was case referred examiner? medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation death. 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

845

32. Registrar's Signatur

To the

Oakwood

29c. License number

D00621

29d. Date signed (Month, Day, Year)

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FREDERICKS Physician/ GGO RGE MERCE 7:10 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death BUCHANAN DRIVE WAUKERSVILLE 5K60 GRICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 214-92-7620 Hours Director 1 **Ø**M 2 □ F 1966 MD. FCB. 23 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Mb. FREDERICK WALKERSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 8(97 BUCHANAN DRIVE W Z V items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ı "natural", or item edical Examiner n 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Yes. Give Specify: BLACK 3 Widowed 4 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) AND SCAPING CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FKEDERICKS. 600RGE DEBORAH GRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICKS, S.R. 8197 BUCHANAN DR. WALKERSVILLE MD. GEORGE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State RESTHAUGH MEM. GARDON MAY 16, 2012 PREDERICK 4 ☐ Donation 5 ☐ Other (Specify) FUNDALL HOME 21. Signature of Funeral Service Ligens . ROILINS Lele Yung SOUTH ST FRED BRICK MD 21701 23a. Part 1. Enter the disease, shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Leath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 E FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the attel page 2 should be detached for in the past 12 months? Year Day 1 ☐ Yes 2 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has be performed? 2 🗌 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Albert Foster 0120 May 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Salisburg Wicomico If Under 1 Year If Under-2 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours (Month, Day, Yean 17. Country) Louisiana 1 ₹ M 2 □ F 76 434-48-3963 **Director** Jan Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo MD Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 Civic Avenue 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status unk 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: black Completed 3 🗆 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk logger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Salisbury Nursing & Rehab Ctr 200 Civic Avenue Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 👿 Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W, Baltimore Street
Baltimore, MD 21201 Ronald S. Wade /Director 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate terval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown n signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? eral Director: After this certificate I filled in by the funeral director, pag ☐ Yes 2 No Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 2 NO Other: 1 🗌 Yes ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, hours after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed Day, Year)

State Registrar NVE

who completed cause of death (Item 23a) Type, Print)

32. Registrar's Signature

O.

Dorochulia

MAY 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR G927 5/18/2012 JH State of Maryland/Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Marie Virginia Femister 2012 April April 16, 6:30 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Apex Health Silver Spring Silve Spring Montgomery Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral Days Months 1 □ M 2 😾 F 579-24-2354 88 Director Mar 23, 1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M-dical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County MD 1 ☐ Yes 2 No Montgomery Silver Spring Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1401 Blair Mill Road #312 20901 Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. δ Specify: black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of workingunk life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk Elementary/Secondary (0-12) College (1-4or 5+) unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward L. Williams ပ Calvin Lucille Douve 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20912 Vivian Hill/friend 7401 New Hampshire Avenue #917 Takoma Park, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Ronald S. Wa 22. Name and Address of Facility 655 W. Baltimroe Street State Anatomy Baltimore, MD Board 2120 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3 moths disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of) Physician/Medical attending pl for use as t IF FEMALE: 23c. If ves, outcome pf pregnancy 23d. Date of delivery signed by the a d be detached for 2

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

altimore, Maryland 21215-0036

Physician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
þ		A. C. A.	Did tobacco use contribute to the cause of death? I □ Yes 2 □ No 3 □ Probably 4 □ Unknown
Completed			Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be (25. Was case referred to medical	26. Place of Death (Check of	nly one)
10 B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 F	Residence 6 Other (Specify)
	27. Manner of Death 1 □ X Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Mork? 1 Yes 2 No	ibe how injury occurred
Certification	3 Suicide 6 Could not b 4 Homicide determined	1 28e. Place of injury - At nome, farm, street, factory, office 1 28f. Locate	on (Street and Number or Rural Route Number, r Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 28656

Gaithersburg,MD 20898

29d. Date signed (Month, Day, Year)

APril 16, 2012

Sta	te
Registr	ar

29a. Certifier

29b./Signature

Ravi Passi Advanced 31. Date filed (Month, Day, Year)

and title of certifier

MAY 18 2012

Primary & Geraitric 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLOTTE GERHART **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F Months Days Hours 219-30-4535 August 27, 1935 Maryland 76 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Exa<u>miner must be notified at</u> 1 ☐ Yes 2X No Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or: amy Injury or other traumatic event, the Medical Examiner must be no once. 21224 7102 Eastbrook Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 ☐XNo þ Yes. Give Specify. 3 X Widowed 4 ☐ Divorced Year or Dates: Completed State of Maryland Department of Health & 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mental&Hygiene 12 years Secretary 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Lewis Michelberger Sophie Kleinheitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Celeste Gerhart Daughter 1702 Eastbrook Avenue, Baltimore, Maryland Baltimore, May Date 21, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Oak Lawn Cemetery Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events the burial-trai resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No be detached for Month Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ of Vital Records, 2 No 3 Probably Junknown 1 Yes s certificate has been sig director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ည this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Director: After 1 Natural
2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after 5 To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

15 V

11595

ANDREAS S. D. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

Registrar

RF3-000

Robert Edward (1- For State Certificate of Death		al Hygiene	201	2 1583		
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last) Robert Edward Gibson		2. Date of Death Month May 2, 201	Day Year	3. Time of Death 1852 hrs		
		9596 Farewell Road Columb			4c. County of Death Howard			
Funeral Director		5. Social Security Number 577-96-9938 1 Mm 2 F 7. Age (In yrs. last birthday) If Under Months Usual Residence of Decedent 48 Yrs. 48 Yrs. 48 Yrs.	1 Year If Under Days Hours	Min. 08/13	/1963 Foreig	thplace (State or in minute) WY		
and show any nce.	5	10a. State 10b. County 10c. City, Town or Location 10d. MD Howard Columbia	.8			10d. Inside City Limits 1 Yes 2 No		
death with the Maryland or items 23s or 28s-f show must be notified at once.	Director	10e. Street and Number 9596 Farewell Road 210		10	10g. Citizen of What Cour			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify 0 1 Yes 2 No		in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer White, etc. Whit Specify:	can Indian, Black,		
036 ithin 72 hours ne. r than "natur!	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) Dishwash	ng life. DO NOT u	ind of work done use retired)	16b. Kind of Business/ Restaura	·		
1215-0036 I be filed within 7 natal Hygiene. wret other than	8	17. Father's Name (First, Middle, Last) Vernon Gibson	Sha					
MD 21 and 2 should beath and Mer em 27 is mar	٩	19a. Informant's Name/Relationship (Type, Print) Cecil Ann Gibson StepMother 31929 Co 20a. Method of Disposition 20b. Place of Disposition (Name	ttonwo	od Dr Tem		92592		
Baltimore, permit. Pages I at Department of Hee Important: If ite		Burial 2 X Cremation 3 Removal from State Atlantic Cre	em	05/12/12	Glen Bur	nie MD		
	_		AllenPA	7090 Rid	ge Rd Har	Fun Serv		
Physician /Medical £xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	.,		o, onou, o. nour	Between Onset and Death		
,	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):						
execul an and	<u>Sa</u>	d.						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Specify) 9 Unknown		pregnancy	23d. Date of delivery Month) Day Year		
r, P.O. B ires that the d signed by the	βP	Part II. Other significant conditions contributing to death but not resulting in the underlying ca Cardiomyopathy with Biventricular Dilataion	use given in Part		acco use contribute to			
of Vital Records, P.C. ag Physician: The law requires that ther this certificate has been signed meral director, page 2 should be det	Completed			24a. Was an autops perform 1 Yes 2	y prior to o ned? death?	topsy findings available completion of cause of		
Vital ysician ysician	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Place of Death (C		tesidence 6 🗸 Other	: Scene		
ion of Vi tending Physi eath. for: After this	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) FOUND: Pending 28b. Time of Injury FOUND: 1	c. Injury at Work?	Subject took	ow injury occurred drug			
Division pital or Attendia ours after death.	ertif	3 Suicide 6 Could not be determined (Specify) Single Family Home	fice building, etc.	28f. Location (St or Town, Sta 9596 Farewell	reet and Number or Ru ate) Road, Columbia, MD	ral Route Number, City		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my operand manner stated.						
	Š	29b Henry little of certifier Vell 1996 29c. Li	icense number D.C.M.E.		29d. Date signed <i>(Mol</i>	nth, Day,Year)		
Q		N	re Street, Ba	ultimore, MD 21223	3			
Sta	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 30, per DVR, g927 5-18-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 1^{Day} 2012 1:50 P M Walter George Graham Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours **Director** 218-64-2794 59 1 XM 2 - F 03/17/1953 Balt., MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location Director Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1565 Bentley Cir. 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Industrial Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Dorothy Orwig Wilbur Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1565 Bentley Cir., Bel Air, MD 21015 Vickie Graham - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 05/15/2012 Highview Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) of Funera Servic Licensee Schimunek Funeral Home 22. Name and Address of Facility 610 W. MacPhail Road., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between nset and Deat shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ MYOCARDIAL Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list or chiticals, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tra Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown After this certificate has been signed in funeral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires t within 24 hours after death.

You the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury Grahan, Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20056296 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 South Atwood Rd. Ste: 206 Bel Air, MD, 21014 Jason Birnbaum 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

8 2012

5/11/12

18#180026 1884

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 13, 4:50 P M May Lawrence Seymore Galowin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Director 072-18-0362 1 🛛 M 2 🗆 F Yrs Oct 8, 1924 New York 87 Usual Residence of Decedent show or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 No Bethesda MD Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9 the Medical Examiner must be Funeral 23a 20816 United States 4974 Sentinel Drive #102 items 2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces ō by 1 Never Married 2 Married X Yes Maryland 21215-0036 1 Yes 2 No Specify: natural", 3 Widowed 4 Divorced Completed White Year or Dates. 1943-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ည Henrietta Soalt Robert Galowin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 4974 Sentinel Dr. #102 Bethesda, MD 20816 Mary E. Fowler / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 5/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Failure to Thrive Sequentially list conditions. day hading to immediate cause. Enter Underlying Cause (Disease or injury Cardiomyopathy burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical as 1 been signed by the attending I should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? wenc Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown this certificate has been signal rail director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 10 Hospital 2 **X**No Other: 1 Tes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director; After work? (Month, Day, Year) X Natural injury 5 Pending Accident M Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) the Funeral Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 5 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) May 15, 2012

Registrar DHMH 17 Rev 06-2011

State

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301

May 15,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shanthi Nadar

31. Date filed (Month, Day, Year)

8600 Old Georgetown Rd.

D70241

Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ 11:44P M 15 Alex Charles Graper May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 2275 Hughes Shop Rd. Westminster Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 177-40-0780 63 **Director** 1**X** M 2 □ F 2-6-1949 PA Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ iral", or items 23a or 28a-f s Examiner must be notified Carroll MD Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2275 Hughes Shop Rd. 21158 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify.white ed other than "natural", event, the Medical Exar 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry atal Hygiene. خوr than "r". (Give kind of work done during most of working (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Management 12 Project Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Should be file and Mental F 2 Robert J. Graper Audrey Kennewig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21158 Loretta J. Graper-wife 2275 Hughes Shop Rd., Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Pleasant Valley Cem 5/21/12 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home homas. V. 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYUCARDIAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): ARTENIOSCEROTIC CARDIOVATCULAN DISEASE Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): nding physician use as the burial Physician/Medical certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d, Date of delivery 23b. Was decedent pregnant atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 5 Other (specify) ed by the a detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, DIABETES MELLITUS ivision of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed PROGRESSIVE SUPRAWUCLEAR PALSEY 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy performed? Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: iniury 1 Natural 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

7

Registrar

DHMH 17 Rev 06-2011

State

Dinaly J W

MAY 1 8 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONNUT T WEGLEIN 6535 N. CITARUS ST 450

32. Registrar's Signature

1726394

5/17/12

BALTO MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

D			For State	State of Maryland /	Depa	artment of h	lealth and	Mental Hyg	iene g. No. 2 (012	15836
	Physici /Medio Examin	al	1. Decedent's Name (First, Middle, Last Pauline J. Hyde 4a. Facility Name (If not institution, give Vantage House				or Location of Dea	2. Date of Dear Month May 1,	Day 2012 4c. Count	Year by of Death	3. Time of Death
Ea	Funeral Director		5. Social Security Number 6. Se 003-03-0822	x 7. Age (In yrs. last 92	birthday) Yrs.	ff Under 1 Year Months Days	If Under 24 Hr Hours Mir		1920	9. Birthp Coun New	lace (State or Foreign try) Hampshire
	h the Maryland or 28a-f ehow e netified et	irector	Usual Residence of Decedent	10c. City, To		umbia		1	0g. Citizen of	What Cour	0d. Inside City Limits 1 ☐ Yes 2 ☐ No htty?
130	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multified at ances.	by Funeral Director	5400 Vantage Poin 11. Marital Status 1 Never Married 2 Married 3 Never Married 4 Divorced	nt Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of hif Yes, specify Cub		Specify Yes or No- into Rican, etc.)		ace - Americ ack, White,	
more, Maryland 21215-0036	ed within 72 hou ygiene. ser then "nature it, the Medical Eit, the Medical Eit.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12		(Give life.	dent's Usuaf Dccup kind of work done DO NOT use retire	during most of w d)	orking ame (First, Middle,	16b. Kind of I		
ryland	should be fill ind Mental Hi marked oth umatic even	To Be	17. Father's Name (First, Middle, Last) BErnie Charles Jo 19a. Informant's Name/Refationship (7)		19h Mailir	ng Address (Street	Jos	ephine B Rural Route Numbe	urne11		
ге, ма	Health and tem 27 ie r		CAthleen Helmor	nd/daughter	331		ny Circl	e Silver		, MD	20904
non m	srmit. Pages apartment of a portant: If its by injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other Specify 21. Signature of Funeral Service Licen	Hemoval from State				ard 655 W	. Balti	imore	Street
	Physician /Medical		23a. Part Enter the disease, or compshock or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	/axx	Z he	Baltimore Her the mode of dyi	ng, such as cardi	ac or respiratory and	rest,		Approximate Interval Between Onset and Death
,/60,	path certificate be executed attending physician and for use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequen c. Due to (or as a consequen d.							
O. Box 68	Attending Physician: The law requires that the death certificate be executed refeath. cotor: After this certificate has been signed by the attending physician and better this certificate by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3	□Ectopic pregnanc □ Other (specify)	ey .			Date of deliver	ery Day Year
rds, P.O	juires that t n signed by uld be deta	by	Part fl. Other significant conditions of	ontributing to death but not resultin	ng in the u	inderlying cause gi	ven in Part I.				he cause of death?
vision of Vital Records,	The law requir ate has been si page 2 should	Completed						24a. Was autop perto 1 Yes	med?	o. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
<u>I</u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11				eath (Check only o	ne)		
=	Physic this or al dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER		nt 3 DOA		Home 5 Resid			(fy)
vision (To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)	3b. Time of Injury e, farm, st	M 1 []Yes 2□No		Street and Nu		ral Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	adge, deal n and/or ir	th occurred at the sivestigation, in my	ime, date and pla opinion, death or	ccurred at the time,	date and place	e, and due t	to the cause(s)
)	To the within To the Comp	W	29b. Signature and title of certifier	mp		29c. Licer	No number		29d. Date sign	ned (Month,	Day, Year)
			30. Name and address of person who	completed cause of death (Item 2)	GN		mpia	Marson	7 2	1044	
	St. Regist	ate	MAY 1 8 20	112 /	1	2. 4. 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Charles Joshua 1618 M Hodges 2012 Medical May 16 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 74 Berkshire Road Baltimore <u>Essex</u> 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours 213-07-3859 Director 1 X M 2 D F 97 Feb.6,1915 MD Usual Residence of Decedent 23a or 28a-f show artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🗆 Yes 2 🖵 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 74 Berkshire Road 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. X Yes þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Steel Worker Beth Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Hodges Anna Herz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Olshinsky /daughter 244-A N. 2nd Street NewFreedom PA 17349 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 5/19/12 Rossville MD Portation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Sign f Funeral S Connelly Funeral Home of Essex 21221 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ acute myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 🔲 Live Birth 2 🗀 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ę 1 Yes 2 g Pregnant at time of death q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 XN has Hospital or Attending Physician: The 2 🗌 No 1 Yes Yes Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours after To the Funeral Direc Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D0055157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Point Norm Rd Fort HOWArd MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last 2. Date of Death Physician/ 13 2012 PRULINE MAY 10:20 AM HARRISON Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) AUG. 5 1937 Director 74 SOUTH CAROLINA 577-78-8771 1 M 2 X Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location ms 23a or 28a-f sho must be notified at 10a. State Director 1X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numb 10g, Citizen of What Country? Funeral 16600 VILLAGE DRIVE WEST 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Examiner Armed Force Black, White, etc. or i þ 1 Never Married 2 X Married 2 **X** No Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify BLACK "natural", Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the 10TH PRESSER PRIVATE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 ZIMMEY HILL ANNETTE **JOHNSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772JOSEPH M. HARRISON/HUSBAND 16600 VILLAGE DRIVE WEST UPPER MARLBORO, MARYLAND Health tem 27 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State RIVERDALE CREMATORY 5/21/2012 4 Donation 5 Other (Specify) RIVERDALE, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the of ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 11041 03119 Medical Due to (o Examiner OBSTRUTTIVE GXACER BEDON DREESE Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Examiner as the burial-transit Cause (Disease or injury JUNG & STIVE MS PRI and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year ξ Month Day Pregnant at time of death the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, HIGHSPL Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? 1 Yes 2 No 1 Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After Natural (Month, Day, Year) 5 Pending 1 Yes 2 No M 2 Accident Investigation filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Carthyling Nurse Fraction of To the basis of my income as stated.

Registrar

State

29b. Signature and title of certifier

Clinton, McI

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DL WASECME

32. Registrary Signature

29c. License number

00064961

29d Date signed (Month, Day, Year)

05/13/2012

Registrar DHMH 17 Rev 06-2011

State

Box 68760

P.0.

Records,

Division of Vital

and address of person who completed cause of death (Item 23a) (Type, Print)

6554

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 15,2012 6:25A. MARY E. HARVEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURE CARE NORTH POINT BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 97 219-03-3780 Director 1 🗆 M 2 🗶 F MARYLAND 1-12-1915 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 🗆 Yes 2 🛣 No MD BALTIMORE BALTO. 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 21237 USA 1525 NEIGHBORS AVENUE "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GLEN L. MARTIN 10TH LINE LEADER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o ၉ GEORGE DIMATTEI AGNES PORKNEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 1525 NEIGHBORS AVENUE FRANCES MCDONALD NIECE BALTO.MD. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State GLEN BURNIE, MD. ATLANTIC CREMATORY 5-18-2012 4 ☐ Donation 5 ☐ Other (Specify) Six ture of Funeral Service Livensee 22. Name and Address of Facility S. ZEILER & SON, INC. CHARLES 6224 EASTERN AVENUE BALTO.MD Pad J Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Myheros cl Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) and that initiated events Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐ Yes 2 ☐ Unknown the P.O. s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Onknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 1 Yes 2 No Yes 2, No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural 5 Pending work' 1 🗌 Yes 2 🔲 No death Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69540 5 16/12 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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Pukulle MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Barbara L. Harper 2012 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Blakehurst Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Days 1 🗆 M 2 🗶 F 008-16-4903 93 **Director** Canada Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Timonium Baltimore MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Eastspring Rd. USA 21093 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Was Decodo. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: SpecifWhite 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eveleen Godfrey John Haskell 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stone Ave. Lake Forest, Il. 60045 John Harper/ Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5-18-12 Towson, MD. Hilltop Service Co. 5 Other (Specify) 4 Donation 21. Signature of Juneral Septice Lice ^{22. Name and Address of Facility} Ruck Towson Funeral Home, 1050 York Rd. Towson, md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Smok-e disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760^c use as signed by the attending the detached for use as IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No Division of Vital To the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending injury 2 No 1 Yes Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one nd title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10:45 AM

10d. Inside City Limits

Approximate Onset and Death

Day

2 🗌 No

Year

1 Yes 2X No

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

6701

il Exam	an/ iner	1. Decedent's Name (First, Middle,Last) Thomas Michael Hall, Jr.	Reg. No. 2. Date of Death						
		4a. Facility Name (if not institution, give street and number) 44.15 Washington Boulevard Room #23 4b. City, Town, or Location of Death Halethorpe							
uneral Pirector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthda							
Maryland r 28a-f show any ed at once.	Director	10a. State 10b. County 10c. City, Town or Location Maryland Howard Elkridge 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 Yes 2 XXNo 10g. Citizen of What Country?						
oe nied within 12 nouts arter death with the Maryland nital Hyber than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once	by Funeral Di	6504 Vert Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X XIo 1 Yes, specify Cuban, Mexican, Puerton Dates: 1 Yes 2 X XIo 1 Yes X No specify:							
ene. er than "natur. Medical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th N/A 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret Contractor	Construction						
i Mental Hygi marked othe cevent, the l	To Be Co	Thomas Michael Hall, Sr. Constance	e (First, Middle, Maiden Surname) e B. Redelius Rural Route Number, City or Town, State, Zip Code)						
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		Thomas M. Hall, Sr./ Father 20a. Method of Disposition 1 Burial 2 XX Cremation 3 Removal from State 4 Docation 5 Other Specify: 21. Aganature of Funeral Service Licensee 22. Name and Address of Facility AMBI	dena, Maryland 21122 Date 20c. Location - City or Town, State 18,2012 Glen Burnie, Maryland ROSE FUNERAL HOME, INC.						
sician edical iminer	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying, such as cardiac or each line. But to condition that caused the death. Do not enter the mode of dying the cause or each line. But to condition that caused the death. Do not enter the mode of dying the cause or each line. But to condition that caused the death. Do not enter the mode of dying the cause or each line. But to condition the death line and line and line and line. But to condition the death line and line	g Rd., Arbutus, Maryland 21227 or respiratory arrest, shock, or heart Approximate interval Between Onset and Death						
he attending physician and d for use as the burial - transit	Physician/Medical	■ MENDED	23d. Date of delivery						
s been signed by the should be detache	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cocaine Use	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
has b	Be Cor	25. Was case referred to medical examiner? 1							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical Certification: To	2 Accident 3 Suicide 6 Could not be determined 4 Homicide Cortifier Cortifi	28f. Location (Street and Number or Rural Route Number, City or Town, State) 4415 Washington Blvd Room #23 Halethorpe, MD.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Mas Physician/ dola AUDREY GAIL JOHNSON Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 578-66-8415 Director 1 M 2 F MICHIGAN APRIL 29 1951 61 Yrs. 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 💢 Yes 2 🗌 No PRINCE GEORGE'S GREENBELT 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 20770 USA 7820 HANOVER PARKWAY #203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. o 1 Never Married 2 Married þ Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. BLACK "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT POSTAL SERVICE marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ATHALIA HARRIS JOHN FRANCIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 7820 HANOVER PARKWAY #203 GREENBELT, MARYLAND 20770 SHERRON FRANCIS/DGT 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) RIVERDALE CREMATORY | 5/18/2012 RIVERDALE, MARYLAND Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Punera e Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death signed by the ar 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 Yes 2 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 - No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 🗆 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitionar To the best of my knowledge. Death occurred at the limb date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD 60611 MI on who completed cause of death (Item 23a) (Type, Print) As faw, MD. 8118 Good huckled, Lanham, MD. 20706

State Registrar Name and address of per

Date filed (Month, Day

8 2012

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Day Month 10:50 PM **Physician** 05 Lee OHNSON 2012 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Manor Raltimore
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days 1 M 2□ F 86 03-02-1926 127-22-214 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a, State 10b. County Department of Health and Mental Hygene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "marked Extransfer must be notified at once. 1 Yes 2 □ No Director BAYIMORE MD 10g. Citizen of What Country? 10e. Street and Number 21202 E Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 X es 2 No 1 ★ es 2 ☐ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 □Yes 2 🔊 No Baltimore, Maryland 21215-0036 Specify: BLACK þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 BOLTEN HILL and 2 should be filed within lealth and Mental Hygiene.

m 27 is marked other than College (1-4or 5+) NURSING HOME CHEF 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAttie WHITAKER ENRY JOHNSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LAFAYETTE AVE. BALTO, MO. 21202 SON DUANE 10 HNSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 ment of H 20a. Method of Disposition BATTIMORE, MD 1 Kemoval from State 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 29/12 4 Donation 5 Dother (Specify) ERREPE FUNERALSENS 22. Name and Address of Facility Vaughn 21. Signature of Funeral Service Licensee M0155 MO.21212 BANTO, YORK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between HYPERTENSIVE Immediate Cause (Final CARPIOVASCULA DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 HInknown The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS autopsy performe 2 🗆 No 1 ☐ Yes 2 No 1 □ Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred funeral 5 ☐ Pending investigation Natural nours after death.

neral Director: After the function of the 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28f, Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2012 S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN NIER DRIVE BUSINESS

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\stackrel{\mathsf{Month}}{\mathsf{MAY}}$ Physician/ **JEAN JOHNSON** 10:08A 9. 2012 Medical 4a. Facility Name (if not institution, give street and number)
FREDERICK MEMORIAL FREDERICK 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 162-26-4509 **Director** 1 □ M 2 🗹 F YORK 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director FREDERICK MD. FREDERICK Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5 23a Funeral BROADWAY ST. 308 USA Examiner must 21701 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces' by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) I Hygiene. College (1-4 or 5+) HOME traumatic event, the Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PALMER, SR. n and Mental I ဂ CARMEN JACOBS 1 and 2 should bot Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 BROADWAY ST FREDERICK MD 21701 DEVILLE K. JOHNSON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State SMITHS BURG CREM. MY 14, 2012 SMITHSBURG MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. ROLLINS FUN, Humt 21. Signature of Funeral Service Licenses Zolle zuy 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part 1, Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, of heart failure. List only one cause on each line Onset a Death Immediate Cause (Final Physician/ COPD disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause (Disease or injury Quel to for as a consecution of physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 Yes 2 No this certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 ♠No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) Signature and title of certifier UZ 1936 Mb onelson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) se of death (Item 23a) (Type, Print)
65C THOMAS VOHNSYN OC. FREDERKK, MO 2170Z

Registrar DHMH 17 Rev 06-2011 A. DUNELSON

31. Date filed (Month, Day, Year)

MB

32. Registrar's Signature

was B. park

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	Physicia Medic		1. Decedent's Name (First		ies, Tr	•		2. Date of Dea Month MAY	Day	Year	3. Time of Death 0 428 A M
	Examin		4a. Facility Name (if not insti	tution, give street and number)	•	4b. City, Town, or BA	Location of Death		4c. County	of Death	
	Funeral Director	. 8	5. Social Security Number 243-74-77 Usual Residence of Deced	10 1 2 M 2 🗆 F	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	y, Year)	9. Birthpla Countr	nce (State or Foreign y) NC
	aryland a-f show fied at	Director	10a. State 10b. C		10c. City, Town or L	more				10	d. Inside City Limits
	death with the Maryland r items 23a or 28a-f sho ner must be notified at		10e. Street and Number	on older Street	Apt.	10f. Zip Code	229		10g. Citizen of	What Countr	ry?
ဖွ	s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2	Married 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	er in U.S. 13.	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - America	
-003	2 hours aft "natural", edical Exal	leted		Year or Dates.	16a. Dec	edent's Usual Occup	ation		16b. Kind of B	black linds	ustry
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and	should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or aumatic event, the Medical Exami	To Be	17. Father's Name (First, Mi			٥	18 Mether's Nam	A /1	Maiden Surnam	e)	
Maryland	nd M md M mar	7	193 Informant's Name/Rej	Honship (Type, Print)	19b. Mai	ling Address Street a		ral Route Number		State, Zip Co	21205
	ge 1 and 3 at of Healt it of Healt or other		20a. Method of Disposition 1 Burial 2 Cren	nation 3 Removal from State	cemetery, cre	position (Name of emaker or other place		Date	20c. Location	- City or Tov	vn, State
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		4 Donation 5 □ C		Green	Vaughn	ss CFacily (R	ene Fu	neral	Seni	rces
	20 E 20	H	23a, Part 1. Enter the disea	ase, or complications that caused to List only one cause on each line.	he death. Do not er	nter the mode of dying	g, such as cardiac	or respiratory ar	rest,	0., M	Approximate Interval Between
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09		1—	resulting in deathy Last	d							
Box 68760	Attending Physician: The law requires that the death certificate be ex or death. ector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burial by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No		Fetal death 3	☐ Ectopic pregnand	су			ate of delive	ry Day Year
.O. B	at the de d by the detached		g 🗌 Unknown	g ☐ Unknown onditions contributing to death but	t not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?
ds, P.	requires that the death certi been signed by the attendin should be detached for use	ted by									ably 4 🗆 Unknown
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ON OF V	ng Phys fter this c	ate: To	1 Yes 2 No 27. Mann f Death 1 Natural 5	1 ☐ Inpatier 28a. Date of injury (Month, Day,		of 28c. Injur	4 ∐ Nursing F y at ⟨?		dence 6 - Otl how injury occur		
JONES Division of V	r Attendi ter death irector: A n by the f	ertifica	2 Accident 3 Suicide 6	nvestigation Could not be determined 28e. Place of Injurbuilding, etc.		M 1 L	Yes 2 □ No	28f. Location (City or To	Street and Numb	ber or Rural	Route Number,
νįΩ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2	Medical Certificate:	29a. Certifier 1 1 Ce.	tifying Physician: To the best of midical Examiner: On the basis of exa	ny knowledge, deat	h occurred at the time	e, date and place,	and due to the date	eause(s) and mar	nner as state	ed.
	To the H within 24 To the F u complete	Me	only one) 3 Ce	tifying Nurse Practitioner: To the	best of my knowledg	ge, death occurred at 29c. License	the time, date and p	place, and due to	the cause(s) and 29d. Date sign	manner as s	tated.
	- > - 0		Bendy	Breeze			58141		may	17,	2012
3				erson who completed cause of deal. It is an S			Balt	imove	MD	212	29
1	Sta Registr		31. Date filed (Month, Day, MAY 1820	Year) 32. Registar	's Signature	on Ave					•

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 05 Dolores Louise Day 06 2012 Physician/ Johnson 2:35 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico 1711 Emerson Avenue Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 11-4-1917 212-01-2927 **Director** 1 M 2 XF 94 Maryland Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director Wicomico Salisbury 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1711 Emerson Avenue USA Funeral 21801 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Seamstress Manufacturing Be 17. Father's Name (First, Middle, Last) Edward Gegner 18. Mother's Name (First, Middle, Maiden Sumame)
Anne C. Stephenson permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Johnson (Son) 1711 Emerson Avenue Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem Park 5/10/2012 Elkridge, Maryland 4 ☐ Doylation 5 ☐ Other (Specify) 21. Signatu of Funeral Service Licensee Gary L. Kaufman Funeral Home at MMP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death the Unknown 9 I Inknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perforn death? 1 🗌 Yes 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accider injury work?
1 Yes 2 No 5 Pending after death. Director: Af Accident Investigation completely filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29d. Date signed (Month. Day, Year) e of death (Item 23a) (Type, Print) Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 Year Oj. Physician/ mala Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs 7. Age (In yrs. last birthday) Min Hours **Funeral** 213-66-5471 1 XM 2 - F Yrs Director Apr 4, 1954 58 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10a. State **Funeral Director** 1

Yes 2 □ No Baltimore must be notified 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or USA 21223 permit, Page 1 and 2 should be filed within 72 hours after death with I Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 1217 W. Fayette STreet Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces? unk Completed by 1 Never Married 2 Married white Specify: 1 ☐ Yes 2 X No Specify: 21215-0036 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry unk 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 17. Father's Name (First, Middle, Last) Baltimore, Maryland ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22 S. Greene Street Baltimore, MD University of MD Medical Ctr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state Konald ben Wa 25 Name and Address of Facility Board 655 W. Baltimore Street 21201 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Due to (or as a consequence of): Medical resulting in death) Examiner man Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine FEN the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the ottending the continuation of the continuation. Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ___ Month Day in the past 12 months? signed by the atter Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown andxia 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28d. Describe how injury occurred 28b. Time of 28c. Injury at 28a. Date of injury filled in by the funeral 27. Manner of Death (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 6 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signature

Mukinu Scrulo A Qor Mis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GARE

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lias Masanka C		les-Kabongo 1- For State Registrar	State of Ma	ryland /	Departm Certific			d Mental		Reg. No	21	0	2	584
Physicia	ın/	1. Decedent's Name (First, M		G1.	1	TZ = 1			2. Date of De Month	ath Dav	Year		3. Time of D	
Medical Examir		Elias 4a. Facility Name (if not institu	Masank		aries		ongo b. City, Town, or I	ocation of De	May 15,		c. County of	Death	140011	
		10568 Sugar Berry					Waldorf			1	Charles			
Funeral Director		5. Social Security Number 118-98-008	6. Sex	_	(In yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	+	Min. Nov . 1		1/DD/YYYY) 2008	9. Birth Foreign Cour	place (State Can	ada
any	ŀ	Usual Residence of Deceden 10a. State 10b. Cour		11	Oc. City, Town	or Location	on	-					10d. Inside	City Limits
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Maryland 28a-f show 1 at once.	Director	10e. Street and Number					10f. Zip Code			_	tizen of Wha	t Count	ry?	
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8		3 Widowed 4	Divorced If Yes, Giv		No	1	Yes 2X No	specify:			Specify: E	Blac	ck	
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7	Completed	Elementary/Secondary (0-	2) Colle	ge (1-4 or 54	·)	N - F	-			1	J - A			
215-0036 be filed within 72 ntal Hygiene. rked other than "	2	17. Father's Name (First, Mid	dle, Last)				1	8. Mother's Na	ame (First, Middle	, Maider	Surname)			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Robert		Kabor		N. T.	1	Lolet	cha or Rural Route No		ker	01-1-	7'- O-d-)	
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imore, MD 2 Pages 1 and 2 shoulment of Health and N tant: If item 27 is n or other traumatic	1034	20a. Method of Disposition			20b. Place		tion (Name of cen	netery,	Date	20c.	Location - 0	City or T	own, State	
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Baltimore, permit. Pages 1 at Department of Hee Important: If ite		21. Signature of Funeral Serv	Balu-	ol ,			ame and Address		2605 S. Servic	Shi	irlin	gto	n Ro	ad 22266
Physician		23a, Part I. Enter the disease	or complications t	Hat caused th	he death. Do no					rrest, sh	<u>rlin</u> lock, or hear	gto t	Approxima	22266 ate Interval
Medical	3	failure. List only one cau Immediate Cause (Final disea	9.4 141 1	Blunt Fo	rce Injuries									Onset and eath
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ion of Vital Itending Physician: Icath. Ior: After this certifi the funeral director,	밁	1 Yes 2 No 27. Manner of Death	28a.	Date of Injur	v 28b.	Time of In		y at Work?	28d. Describe	how in	jury occurre	<u> </u>		
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical E	xaminer: On the b											
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7		30. Name and address of per Russell Alexander i	MD. Assista	nt Medica	l Examiner	900 \	V. Baltimore	Street, Ba	ltimore, MD 2	1223				
St Regist		31. Date filed (Month, Day, Ye	8 2012 ³	2. Registrer	s Signature	ba	Red		00W	Ē				
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Physicia	ın/	Registrar 1. Decedent's Name (Fir									2	2. Date of Dea Month		Year	Т	3. Time o	
Medical Exami	ner	Tara Dan										May 12, 2	012			0720	hrs
		4a. Facility Name (if not 2421 Old Robin		-	umber)			4b. City, To Aberde		ocation of I	Death			c. County of Harford	Death		
Funeral		5. Social Security Number	er 6	i. Sex	7. Age (In yr	rs. last	birthday)	If Under	_	If Under 2		8. Date of Bir		l F	9. Birth oreign		tate or
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any		Usual Residence of Dec	edent County	-	10c. C	ity To	wn or Locati	ion		_						10d Insid	de City Limits
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5-0036 led within 72 hours after death with the Maryland thygiene. other than "natura!", or items 23a or 28a-f ab.	à	3 Widowed 4 15. Decedent's Educati		ced If Yes, Give Yes or Dates: y only highest gra		1) 16	3a, Deceden	Yes 2.2 t's Usual 0			d of wo	rk done	16b.	Specify: Kind of Busir			
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Baltimore, permit. Pages la Department of He. Important: If ite		21. Signature of Funeral	Service U	ens≢				lame and A									Serv
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Division al or Attendi rs after death. al Director: A	ifica	2 X Accident 3 Suicide 6	Investi	28e Plac	e of Injury - A				office bui	lding, etc.		8f. Location (S	Street a	and Number	or Rura	al Route I	
Divising the state of the state	Certification:	4 Homicide	determ	ined (Specify)	Four	nd:	Reside	nce				berdee	en,Î	D.		OU LII	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Onlock only		sician: To the bearing: On the basis													
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Official	1	30. Name and address of											<u></u>				
7 4		Russell Alexand		Assistant N	/ledical Ex	amin	er 900	W. Baltir	nore S	treet, B	altimo	re, MD 21	223				
Sta Regist	ate rar	31. Date flad (Monto D	012	Denn 32. P.	egistra s Sig	A COL	100										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:00 A M 2012 Raymond William Kadow May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Gilchrist If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Months (Month, Day, Year) Director 276-20-1458 1 🗶 M 2 🗆 F Yrs Ohio 1925 87 Mar 28, Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 X No Catonsville Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 21228 United States 707 Maiden Choice Lane #8G11 death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status ıral", or iten Examiner ı Armed Forces? Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates. 1943-46 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Communications Electrician if Health and Mental Hygir item 27 is marked other other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Walter Kadow Clara Kobabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Maiden Choice Ln #8G11 Catonsville, MD 21228 Betty Jane Kadow / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date ō <u>=</u> ₀ 1 Burial 2X Cremation 3 Removal from State Department of Important: If any injury or Final Journey Crematory 5/18/2012 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ears Physician/ disease or condition resulting in death) Medical Du to (or as a con venc of) Examiner Sequentially list conditions, Examine Due to (or se a consequence of) cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the b IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonia has page 2 performed? autopsy 1 Yes 2 No certificate 1 Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Hospital: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSDICE 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury 24 hours after death. Funeral Director: Af 2 🗌 No Accident Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check within 2 To the F To the I only one) 29b. Signature and title of certifier D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANE COLUMBIA Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0 Baby Boy Kwafo Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Ba 8. Date of Birth (Month, Day, Year) May 5.2012 Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 1 🛣 M 2 🗆 F Months infant Director Maryland Usual Residence of Decedent or 28a-f shov 10b. County 10c. City, Town or Location 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2X No Middle River Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 Southorn Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify black. If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry during most of working Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Veronica Kwafo John Kwafo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9300 Franklin Square Drive Rosedale, MD Franklin Square Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Donate (Specify) Si nature of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Raltimore MD Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, scheart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical use as the IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No signed by the atte Month Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, it 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🛮 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, Homicide determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) Matitle of 29b. Signatur 2

State Registrar 31 Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04:29 AM Ka 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arund Arunda Medica ente Annapo Anne Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Maryland 1 **№** M 2 🗆 F (Month, Day, infant Director Usual Residence of Decedent 23a or 28a-f shov 10a. State 10h County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Inite "natural", or items 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc 1 Never Married 2 Married <u>6</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Whit If Yes, Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic content. College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shira 810 Mother View Circle Pasadena Ann 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 🛛 Othe (Specify) in state Signature of Funeral Service Licensee Rend Ld S Wade ²² State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Atrema Pnysician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death be detached Unknown Unknown à Part II. Oth<mark>er significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available 24a. Was an has autopsy performed Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 2 × No 1 🗌 Yes 2 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending (Month, Day, Year, 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Rindt 1 eisch 2001 Medical Lanne

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 8 2012

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 9, 2012 Gloria May Krebs Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper Hospice House Forest Hill Harford Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Director 213-28-1390 1 M 2 X F 79 July 3, 1932 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director must be notified 28a-f MD Harford Edgewood 10:05am 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with ti Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Manager of the state of the standard of the s Funeral 1204 Paul Martin Drive 21040 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 2X No 1 ☐ Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Miller Rosalie Caprarola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3951 Old Rocks Road Street, MD 21154 3951 Old Rocks Road Street, MD Chris Whitesel/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Si inatur of Funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 No 9 Unknown Month Pregnant at time of death 9 Unknown been signed by the should be detach of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Yes After 1 28d. Describe how injury occurred 5 Pending Natural injury I Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours at er within 24 hours a To the Funeral C the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, bate and place, and due to the cause(s) and manner attack. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 합 29b. Signature a 29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10:05 AM

9. Birthplace (State or Foreign

10d. Inside City Limits

Onset and Death

Day

1 Yes 2 No

3 ☐ Probably 4 ☐ Unknown

Year

1 Yes 2 No

Maryland

white

USA

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 16 2012 9:07p M Guy Neil Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-03-5851 Director 1 X M 2 □ F 26,1918 Maryland 94 Feb. Usual Residence of Decedent and Mental Hygiene.
and Mental Hygiene.
/ Is marked other than "natural", or items 23a or 28a-f show
reumetic event, the Madical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 🗆 Yes 2 🖾 No 10e. Street and Number 10g. Citizen of What Country? Funeral 717 Maiden Choice Ln. Apt.ST406 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married XYes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes. Give Specify: Completed 3XXWidowed 4 ☐ Divorced Year or Dates 940 – 194 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter <u>Teachers Asso</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Heelth and Ments fitem 27 is marked rother treumetic e Minnie Salome Catterson Guy Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Highfield - daughter 942 Litchfield Cr. Westminster, MD. 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of Important: if it any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Mem. Park May 21,2012 Sykesville, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A . Darts Tehen <u>11605 Reisterstown Rd.</u> Owings Mills, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Physician/ UNKNOWN PRIME disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of: signed by the attending physician and deed be detached for use as the burlal-trensit law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 分中known 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfortned 1 🗆 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 1 Tes 잍 1 Inpatient 2 ER/Outpatient 3 DOA

Box 68760 P.O. I Division of Vital Records, Hospital or Attending Physician: The the funeral director, within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun

28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be

determined

Other: 4 Nursing Home 5 Residence 28c. Injury at 1 Tes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one)

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

and title of certifie

DHMH 17 Rev 06-2011

State Registrar

Certificate:

Medical

29b. Signatu

12-03297 Laura Lupo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 15856 1- For State Certificate of Death Rea, No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 28, 2012 Medical Examiner 0440 hrs Laura Lupo 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Fort Washington Hospital Fort Washington Prince George's 5. Social Security Number unk 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Days Months Hours Director Country Nary Land 2X F 52 Aug 22. 1959 Usual Residence of Decedent I 0c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County unk 1 Yes 2 No show VA Alexandria I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4512 Lack Lane 22310 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Armed Forces Married 2 X No Yes 5 1 Yes 2 No specify: 4 Divorced If Yes, Give Year white ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 0 disabled none 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ray Burcham Kathryn Grahe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Burcham/mother 12235 Kane Alexander Drive Nuntersville, NC 28078 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in 21. Signatur o Funeral Servic Licensee 22. Name and Address of Facil State Anatomy Board 655 W. Baltimore Street 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Cocaine and Phencyclidine Intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Atteoding Physiciao: The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g927 5-21-12 sm X UNPENDED signed by the attending physician be detached for use as the burial -Division of Vital Records, P.O. Box 68760, IE EEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 V Unknown Completed r this certificate has been so al director, page 2 should b 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 2 No 1 🗸 Yes 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 1 Yes 2 X No unknown Pending hours after death. Director: d in by the fd 4-28-12 fd 03:32 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)400 Potomac Valley Dr Fort Washington, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be determined (Specify) Found: Residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 24] Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mas O.C.M.E. April 29, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Pay, 32. Registrar's Signature State 8

DHMH 17 Rev 1/2001

Registra

OCME

12-03700

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Diane Laird	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2012	585
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of De Month Day Year 4705 Le 4	
Medical Examine	Diane Laird May 14, 2012 1/35 hr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	•
	Johns Hopkins Bayview Medical Baltimore	
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) ff Under 1 Year ff Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State Foreign Country) Mary	
áu é	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside C	ity Limits
	Maryland Baltimore Dundalk 1 Yes	2 X No
tified Dir	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA USA	
r death with , or items 23	11. Marital Status 1	ick,
irs after tural?, iminer	3 Widowed 4 Divorced of Specify: 1 Yes 2 No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
5-0036 ed within 72 hour bygiene. other than "natt the Medical Exau Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	
within within Media Media	12 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica To Be Comple	Shearl S. Harden Norma Leona Yoor	
D 21; hould the hould the Mer is mar tic even	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
and 2 s ealth ar cen 27	William Laird HUsband 107 Maryland Avenue, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, permit. Pages I ar Department of Hee Important: If itee Imjury or other tr	1 Burial 2 X Cremation 3 Removal from State Bayview Crematory 21, Baltimore, Maryla	and
Bal permi Depa Impo	27 Signature of Funeral Service Licenson 2 22 Name and Address of Facility Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222	2
Physician	23a. Part I. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Between Or	Interval
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Morphine) Intoxication Due to (or as a consequence of):	
9	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
led Insit Examiner	C) Colleges or injury that initiated expert regulting in (east)) last consequence of):	
cuted and transit	events resulting in death) Last Due to (or as a consequence of): d	
0, e be executed ysician and burial - transit ledical Exa	■ AMENDED 23a,27,28a-f,per me,g928 6-1-12 sm	
Box 68760, a death certificate be the attending physici ad for use as the buring hysician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Month Day Y	'ear
b. Box 6876 the death certificate by the attending phy ched for use as the b	past 12 montris? 4 Pregnant at time of death 5 Other (Specify)	
P.O. Be that the de ned by the detached f by Phy	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de	eath?
i, P.C	1 Yes 2 No 3 Probably 4 Vu	iknown
ords, w requir us been s should I	24a. Was an 24b. Were autopsy findings autopsy prior to completion of ca	
Records, The law require ficate has been sign, page 2 should be Completed	performed? death? 1	No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Othe	
n of Vi ting Physi After this funeral dir	1 Yes 2 No 1 Injury 2 P Produpater 3 DOA 4 Norsing Home 5 Residence 6 Other. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) (Month, Day, Year)	
ion ttendir feath. for: A	1 Natural 5 Pending Investigation fd 5-14-12 fd 04:59 pm 1 Yes 2 x No unknown	
Division of Vital Records, P.O. pital or Attending Physician: The law requires that th ours after death. seral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be deach Certification: To Be Completed by P	Suicide Homicide Could not be determined Specify Found: Residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Found: Residence 28f. Location (Street and Number or Rural Route Number or Town, State) 107 Maryland Ave Dundalk, MD.	er, City
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the behavioral Certification: To Be Completed by Physician/IM	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
Ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 15, 2012	
	30, Name and address of person who completed cause of death (Item 23a)	
Ø	Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	31. Date filed (Month, Day Year) 32. Fegistrar's Signature	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / De			1ental Hy	giene		
		_1	State Registrar	C	Certificate of E	Death		Reg. No. 2	112	15858
	Physicia		1. Decedent's Name (First, Middle, Last) HAZEL L Mi	llen			2. Date of Dea	Day	Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give st.		4b City Town, or	Location of Death	11009	4c. County	of Death	17.122
	Examin	er	312 Marydell Rd.		Baltin			N/A	o. 5 od.,	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h (a Year)	9. Birthpla	ace (State or Foreign
	Director		367−36−5364 1 □ Usual Residence of Decedent	M 2 泵 F 74 Yrs			Dec. 1	2 ^{Year)} 1937	North	Carolina
	and show Lat	or	10a. State 10b. County	10c. City, Town o	r Location				10	d. Inside City Limits
	Maryla 28a-f	irect	MD N/A	Baltimor	е					1 X Yes 2 No
	h the	al D	10e. Street and Number		10f. Zip Code	_		10g. Citizen of V	Vhat Countr	y?
	ith wit ms 2; must	Funeral Director	312 Marydell Rd.	2. Was Decedent Ever in U.S.	21229 13. Was Decedent of Hi		ecify Yes or No-	USA 14 Bace	- Americai	n Indian
9	er dez or ite miner	by Fi	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 █ No	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Blac	k, White, et	c.
003	ırs aft ural", II Exa		3 X Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2X No				Whit	
15-(72 hou	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (G	ecedent's Usual Occup Give kind of work done o e. DO NOT use retired)	ation during most of work	ing	16b. Kind of Bu	ısiness/Indu	ıstry
212	within 72 hours after death with the Manyland giene. then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.		Elementary/Secondary (0-12)	College (1-4 or 5+)	amstress			Factory	7	
nd	filed valued of other		17. Father's Name (First, Middle, Last)	D .		18. Mother's Nam	-	_	:)	
yla	should be filed thand Mental Hyg 7 is marked oth traumatic event	입	Mack	Dirmore			Lena	Orr	7.0	
Mai	ge 1 and 2 should be filed within 72 hours after death with the Manyland ti of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type David E. Miller		Mailing Address (Street a					ide)
ē,	1 and 2 s of Health item 27 other tra		20a. Method of Disposition	20b. Place of D	Disposition (Name of crematory or other place		Date	20c. Location -		n, State
imo	Page nent c ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Loudon	Park Cemet	ery 5/18		Baltimo:		
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or ot		21. Signature of Funeral Service License		22. Name and Addres					
	00 2 6 0	\dashv	23a. Part. Enter the disease, or compli	cations that caused the death. Do not		kens Ave.				Approximate
	Physician/		shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequence of):						
	Examiner	<u>ا</u> ا	Sequentially list conditions,	but to for se a cure cure or un					_	
	ed nsit	Examine	cause. Enter Underlying Cause (Disease or injury	Date to (or set a consistent on co)					1	
8	execut in and ial-tra		that initiated events resulting in death) Last	Due to (or as a consequence of)	:					
09	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		i						
Box 68760	ertifica ding pl	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy				22d Do	te of deliver	
×o	attend I for us	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су				Day Year
). B	the de	hysi	g Unknown	g 🗌 Unknown						
P.	s that gned I be dei	þ	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause gi	ven in Part I.	10			e cause of death?
rds	equire	eted					24a. Was			sy findings available
eco	sician: The law r certificate has b lirector, page 2 s	Completed					auto perfo	psy prmed?	prior to com death?	pletion of cause of
E E	an: The tificate tor, pa	Be Cc	25. Was case referred to medical		26. P	lace of Death (Chec	1 🗌 Yes k only one)	2 L No	1 🗌 Yes 🔏	2 🗀 190
Vita	Physicia this cer ral direc	To B	examiner? 1 Yes 2 No	ospital: 1	patient 3 DOA Oth	er: 4 Nursing H	ome 5 Resi	dence 6 Oth	er (Specify)	
o l	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Tin	ury work	k?	28d. Describe I	now injury occurr	ed	
sior	death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm		Yes 2 No	28f. Location (Street and Numb	er or Rural I	Route Number,
Division of Vital Records, P.O.	al or A s after il Dire		4 Homicide determined	building, etc. (Specify)			City or Tov	vn, State)		
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check 2 Medical Evamin	cian: To the best of my knowledge, de er; On the basis of examination and/or i	investigation in my onini	on death occurred a	t the time date:	and place and du	e to the caus	se(s) and manner stated.
	the lithin 2 the long	Me	only one) 3 Certifying Nurse	Practitioner: To the best of my knowledge	edge, death occurred at 29c. Licens	the time, date and pl e number	ace, and due to	the cause(s) and r 29d. Date signe	nanner as st d (Month, D	ated. lay, Year)
	Vit To		> nskajupak	NIMO		00057	465	5/	16/1	2_
	5		29b. Signature and title of certifier 30. Name and address of person who co	empleted cause of death (Item 23a) (Ty	rpe, Print)	2 - 15	3 111	717:		
	Cto		N) Kug af a k & (MI) 31. Date filed (Morth, Dav. Year)	32 John M	1 605 1	Ja myon	- 1-11)	616	7	`
	Sta Registr	ie ar	MAY 1 8 20	12 Dewa S.	barles					

Funeral Director

. 0		>		Usual Residence C	Decedent	
0		ind ihov	5	10a. State	10b. County	
MAY 61 201		permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	MD	Montgon	ery
6		a or 2		10e. Street and Nu	ımber	
>		s 23	Jer	1713 Ki	ng James	Way
7		leath item er rr	Ē	11. Marital Status		12.
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	003	urs af ural" al Exa	ted	3 🗌 Widowed		
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5	br	illed vall Hyg	Be		(First, Middle, Last)	
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トラ	Man	shoul and I is ma			Name/Relationship	
Z	<u>ک</u>	and 2 lealth		Monique	Morant/d	aug
X	ore	t of t		20a. Method of Dis	sposition 2 Cremation 3	Rem
10	Ë	Pag men ant: ury		4 Donation	70	
5	Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other tha any injury or other traumatic event, the lonce.		21, Signature of F	uneral Servir e Licen	Wat
		00200		100	mole	1
	н			23a. Part 1. Enter shock, or he	the disease, or con art failure. List only	iplicat one ca
	1	Prysician/	0	Immediate Cause disease or condit	(Final	
		Medical		resulting in death	•	а
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		_	<u>=</u>	Sequentially list of it any, leading to cause. Enter Und	mmediate	D. =
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	376	ficate g ph) as the	Jed Jed			
	39	ndin use	S	IF FEMALE: 23b. Was deceder	nt pregnant	23c.
	ŏ	atte atte	cia	in the past 12	2 months?	
	Ξ.	the deched	Jys	9 Unknow		
	Records, P.O. Box 68760	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical Examiner	Part II. Other sign	ificant conditions	contrib
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	orc	/ requ	ete			
	Ö	e law e has ige 2	Ĕ			
	_			25. Was case refer	rred to medical	
	Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical Certificate: To Be	examiner?	□ No	Hosp
	£	Phy r this ral d	 	27. Manner of Dea		
	n C	nding tth. : Afte	cat	1 Natural 2 Accident	5 Pending Investigation	n l
	Sio	Atter r dea ctor y the	臣	3 Suicide	6 Could not I	be -
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		e Ho 1241 9 Fur	led	(Check only one)	2 Medical Exam	nîner:
		orthin orthin	2	29b. Signature and		/
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	1	State Registrar						Certific	cate of L	Death			Reg. N	0. 2) 2	2	1585
sician/	1	1. Decedent's Name	e (First, Middi	e, Last)								2. Date of De Month		ay _	Year		me of Death
ledical	1	Craig A a. Facility Name (if			et and num	aher)		416	City Town	Leontina	f Dooth	May 6,			-f D - Ab		:41 PM
aminer	4	Shady G					a1		City, Town, or		T Death		4	c. County Mont	of Death tgome		
eral	5	. Social Security No		6. Sex		7. Age (In y		day) If L	Inder 1 Year	If Under		8. Date of Bir	th		9. Birth	place (S	tate or Foreig
ctor	L	063-42-1		1 🔀 1	M 2 🗆 F	62	2 Y	rs.	nths Days	Hours	Min.	Apr 28	$\frac{1}{1}$	950	Ne	w Y)rk
# F	15	Jsual Residence of I 0a. State	10b. County	,		10c.	City, Town	or Location	1							10d. Insi	ide City Limits
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E E		1. Marital Status			Armed Fo	edent Ever in rces?	U.S.	13. Was E If Yes,	ecedent of H specify Cuba	spanic Orig n, Mexican	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)			e - Amerie k, White,		an,
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		Isaiah		,								e(First, Middle, na Whit		i Surname	*)		
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	1	Monique	Morant	/dau	ghter							Germant			208		
once. To Be Completed by Funeral Director	2	20a. Method of Disp 1 Burial 2 4 Donation	Cremation			State	b. Place of cemetery		(Name of or other place	:e)	ſ	Date	20c.	Location -	City or T	own, Sta	ate
once.	1	21. Signat in Fu					or			-		d 655 V	J. E	alti	nore	Str	eet
	Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a															Interv	ximate al Between and Death
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ıysician/Me	1 2	F FEMALE: 23b. Was decedent in the past 12 I 1 Yes 2 S 9 Unknown	months?	230	1 Live	tcome of pre Birth 2	Fetal death		opic pregnander (specify)	;y				23d. Dat Mo	te of d e liv	very Day	Year
by Phy	Ţ	Part II. Other signif	icant condit	ons contr	ibuting to d	leath but not	resulting in	the underl	ying cause gi	en in Part I		23e. Did t	obacco	use contr	ribute to t	he caus	e of death?
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년 8	41	examiner?	□No	Hos	spital:	Inpatient 2	ER/Out	patient 3	DOA Oth	er: 4 🗌 Nu	irsing Ho	ome 5 🗆 Resi	dence	6 🗆 Othe	er (Specif	y)	
ie.		27. Manner of Death	5 Pend	ina	28a. Date (Mon	of injury th, Day, Year	28b. Ti	me of jury	28c. Injur work	y at		28d. Describe					
Certificate:		2 Accident 3 Suicide		igation	00- 5:	at let	A h	N	1 1 🗆	Yes 2 🗆		201				-	A
Cert		4 Homicide	deten			e of Injury - A ing, etc. (Spe		n, street, fa	actory, office			28f. Location (City or To			er or Rura	u Houte	wumber,
Medical Certificate: To Be Comp		(Check 2	Medical	Examiner	: On the bas	sis of examina	ation and/or	investigation	n, in my opinie	on, death oc	curred at	nd due to the ca t the time, date a ce, and due to the	and plac	ce, and due	e to the ca	ause(s) a	nd manner sta
_		29b. Signature and			20	2	1	M	29c. Licens		26	7/		ate signed			ar) /2
	3	30. Name and address	1		pleted caus		Item 23a) (T	iype, Print) Cent	er Dn	ve, 1	Rock	ville / M	lary	lord	209	50	
State	3	31. Date filed (Mont	h, Day, Year)	1	-	Registrar's Si											_
strar		MAY 1.8	2012	A.		A L	2. 40 1	•									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar Fayam Soltanza boh, MD

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAYAM SOLTANZADEH, 110 S. PACA ST, 3rd Floor, Department of NEUROLOGY, BALTIMORE, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201 pri Medical 4a. Facility Name Mnot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Regional Hospita -dure 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 579-94-453 Hours Min (Month, Day, Year) **Director** 1 🗆 M 2 🗶 F WASHINGTON, DC 18.1967 28a-f show 10c. City, Town or Location notified at 10d. Inside City Limits by Funeral Director Prince LAUREL MD owae5 1 X Yes 2 No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? pe Ush foro 14816 20707 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK "natural", Completed 3 Divorced 4 Divorced In and Mental Hygiene.

27 is marked other than "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Secondary (0-12) College (1-4 or 5+) RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GASTON မ INEODORE EMILY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agelic B. Matthews Department of Health a Important: If item 27 is any injury or other trau once. DAVGHTER LOVREL. 14816 ASHUKO hod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State 5.12.2012 Riogeland, SC LOW BOTTOY CEM 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22204 -obest \mathcal{B} 2605 5 Shirlington RD CHIMUBAKER Allington, 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Embolism Massive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine neumonia burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ should be detached for in the past 12 months? Month Day Pregnant at time of death 2 No Unknown 9 X Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗶 No Other: မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director, After t Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral E Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier D41248 7300 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OKang, MD Regional

DHMH 17 Rev 06-2011

State Registrar

George

Hospital

Laurel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOS DITA . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 024-28-8720 **Director** 75 1 🛣 M 2 🗆 F July 6 1936 Massachusettes or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2327 Boston Street Unit 1 21224 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Physician Research traumatic event. Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked oft any Injury or other traumatic even any Injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henry Molliver Gertrude Leschner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erica Molliver / Daughter 4600 Connecticut Ave. N.W. #404 Wash. DC 20008 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/17/12 HilltopServiceCorp. Towson, Maryland 21. Signature of Funeral Service Lie 22. Name and Address of FacilityRuck Towson Funeral Home, 1050 York Road 21204 Towson, Maryland 23a. Part 1. Enter the disease, or condicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Intanctio disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 300014 Examine Directo for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 | No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work≀ 1 ☐ Yes 2 ☐ No I Director: Af within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fu ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soti sh 1816 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 15863 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 16,2012 4:40 P.M WILLIAM M. MORLOCK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TIMONIUM BALTO. STELLA MARIS Social Security Number 6. Sex If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 217-22-3560 **Director** 1**★** M 2 □ F 84 9-22-1927 MARYLAND Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo BALTIMORE KINGSVILLE MD. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6940 NEW CUT ROAD 21087 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No WHITE 3 ★ Widowed 4 □ Divorced Specify. Completed Year or Dates. 1946–1952 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) ELECTRICIAN WESTINGHOUSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ JESSE E. MORLOCK LILLIAN MILLER 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINGSVILLE, MD. 21087 MICHAEL MORLOCK SON 6940 NEW CUT ROAD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ST. JOSEPH 5-18-2012 FULLERTON, MD. 21. Signature of Funeral Service (10) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 ☐ No 1 Yes 2 9 Unknown q I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ڄ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 0 No Yes 2 📉 N 1 Yes 25. Was case referred to medical Division of Vital Be B 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) HOSPICE ျှ 1 🗌 Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation To the Hospital or Atter within 24 hours after des To the Funeral Director completely filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date 13X, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNA 2300 Dulcene ra M.

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

2109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayorth 13, 2012 Lester J. MELNICOVE 9:02 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** unty of Death Bethesda Montgomery Suburban Hospital Social Security Number 1 Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days 579-26-2807 1**X** M 2 □ F Director 87 Jan. 23, 1925 Virginia show 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? must be Funeral items 23a 5450 Whitley Park Terrace #702 20814 United States 12. Was Decedent Ever in U.S.
Agmed Forces?
11 Yes 2 □ No
If Yes, Give
Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married "natural", or β 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Specify: white Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Vice Pres. of Const. & Design The Hecht Company Be 18. Mother's Name (First, Middle, Maiden Surname)
Reba Yaffey 17. Father's Name (First, Middle, Last) Samuel Melnicove 19a. Informant's Name/Relationship (Type, Print)
Barbara Melnicove, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park Terrace #702, Bethesda, MD 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 05/16/12 Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Adas Israel Congregation Cemetery Washington, DC e Licensee Poweringly Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Part 1. Swer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Years Cardiomyopathy Esquerniary list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Years Hypertension Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) P.O. Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Metastatic Bladder Cancer 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Vascular Disease page 2 autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No funeral director, 25. Was case referred to medical of Vital Certificate: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🙀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a To the Funeral I Medical 29a Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) May 14, 2012 25*1 MD 33244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph A. Vassallo, M.D., 5454 Wisconsin Ave., #925, Chevy Chase, MD 20815 State

Registrar

			For	State of Maryland	d / Depa	artment of H	lealth an	id Mental Hy			1500
			State Registrar		Cer	tificate of E	Death		Reg. No. 2	0 2	1586
	Physicia	an/	Decedent's Name (First, Middle, La	st)				2. Date of De		_ Year_	3. Time of Death
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	Examir	ner		ŕ		4b. City, Town, or		eath eath	4c. County	_	
	Funeral		2251 Grimville Ro		st birthday)	If Under 1 Year	Airy If Under 24	Hrs. 8. Date of Bir		roll 9. Birtho	lace (State or Foreign
	Director		326-42-3727	X M 2 □ F	Yrs.	Months Days	Hours N	vlin. (Month, Da	ay, Year)	Count	(unk)
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	death v items ner mu		11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?			spanic Origin?	(Specify Yes or No-	14. Rad	ce - America	an Indian,
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Baltimore,	% ≒ ∵ ∘		1 Burial 2 X Cremation 3 4 Donation 5 Other (Speci	Removal from State ce	metery, crem	atory or other place	1 1			-	
altii	permit. Page Department o Important: If any injury or once.	10	21. Sign of Funeral Service Licen	T LIKIT		ey Cremat					Maryland
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the death.							Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	Acute Myoca	rdial	Infarctio	on				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
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nie –	red nsit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Morbid Obes							
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0 X	eath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand	death 3 🗌	Ectopic pregnancy	/			te of deliver	*
Box.	the a	ysic	1 Yes 2 No	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5 □	Other (specify)			IVIC	onth I	Day Year
P.O.	that the dealed by the a detached	y Ph	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the un	derlying cause give	en in Part I.	23e. Did to	obacco use conti	ribute to the	e cause of death?
ls, l	n sign	Completed by	Nicotine Overuse	e (smoking)				1 🗓 🗓	Yes 2 No	3 🗌 Prob	ably 4 🗆 Unknown
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3ec	The law ate has page 2	mo							rmed?	prior to com death? 1 □ Yes :2	pletion of cause of
a	sician: The certificate irector, pag		25. Was case referred to medical examiner?			26. Pla	ce of Death (C	Check only one)	Z KN NO	i ∟ res ⊿	<u>2</u> □ INO
of Vital Records,	Physic this ce al dire	은	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ E		3 DOA Other	r: _ 4	g Home 5 🔀 Resid	dence 6 Othe	er (Specify)	
J of	ding P h. After t funera	Certificate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	8b. Time of injury	28c. Injury work?	•	28d. Describe h	ow injury occurre	ed	
Division	pital or Attencours after deatheral Director; villed in by the	tific	2 Accident Investigation 3 Suicide 6 Could not b		e form etro		res 2 □ No	001 1 10 (0			2 1 1 1
.≥	i gird		4 Homicide determined	building, etc. (Specify)	e, iam, sue	st, lactory, office		City or Tow	Street and Numbern, State)	er or Huraj F	Houte Number,
_	Hospital 24 hours a Funeral I etely filled	Medical	29a. Certifier 1 Certifying Physics	sician: To the best of my knowled	dge, death or	curred at the time,	date and place	ce, and due to the ca	ause(s) and manr	ner as state	d.
	the the		only one) 3 Certifying Nur	iner: On the basis of examination are Practitioner: To the best of my	and/or investig	ation, in my opinion	 death occurr 	ed at the time date a	nd place and due	o to the caus	sels) and manner states
	To t To t		29b. Signature and title of certifier	Quesh		29c. License	number		29d. Date signed	d (Month, D	ay, Year)
P			J,	X8 mis			2663		May 1	4, 20	12
	1		30. Name and address of person who				NAT	21157			
	Stat	e	31. Date filed (Month, Day, Year)	MD 4212 Ridge 32. Project rar's Signatur		es cultus te	er, MID	2115/			
	Registra	_	MAY 1 O DO								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 30 per DVR, G927, 57, 187, 2012, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:50 Physician/ Maryth 14, 2012 Рм Omro Mills, Jr. Leland Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 6733 Deep Run Parkway Elkridge Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 216-36-9785 **Director** Yrs 06-29-1940 Maryland 71 Usual Residence of Deceder 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Elkridge MD Howard 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a Funeral United States 6733 Deep Run Parkway 21075 death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Transportation Transit Operator 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Irene Thomas Leland Omro, Mills, Sr. Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6733 Deep Run Parkway, Elkridge, Maryland 21075 Donna K. Mills - wife 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park ¦05-17, 2012| Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. kaufman Funeral Home at of Funeral Service Ligense 21. Signatur MMP, Inc, 7250 Wash. Blvd, Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Non Small etastatic disease or condition Medical resulting in death) 21/2 yrs Due to (or as a consequence of): Examiner Gequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate I Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 2 No 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tejaswi Sastry 10710 Charter Drive Columbia, Md. 21044 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

12-03734 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Margaret Mary McCabe State of Maryland / Department of Health and Mental Hygiene 2012 15867 Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 15, 2012 Margaret Mary McCabe 2203 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1701 A W. Bancroft Lane Crofton Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Wash., DC Days Min. Months Hours 04/29/1936 Director 76 XX 1___ M UNK Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. Count Crofton e notified at once. MD Anne Arundel 1 Yes 2 X No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho
rights or other traumatic event, the Medical Examiner must be neitified at once. Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21114 1701 A W. Bancroft Lane Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes White 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year Specify Š 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher 18 Mother's Name (First, Middle, Maiden Surname) Mary J. Kane 17. Father's Name (First, Middle, Last) Joseph J. McCabe Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. McCabe / Brother 8 S. Wynstone Dr., N. Barrington, IL 60010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 05/17/2012 Odenton, MD W. Arundel Crematory Donation 5 Other Specify 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, 4023 Annapolis Rd., Halethorpe, MD 21227 21. Signature of Funeral Service Licenses M01452 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit law requires that the death certificate be executed physician a UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day use as past 12 months? Pregnant at time of death 5 ned by the atte 1 Yes 2 V No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be be deta þ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an certificate has been autopsy prior to completion of cause of death? performed 1 🗸 Yes Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certific 26, Place of Death (Check only one) 25. Was case referred to medical å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene ဥ 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 1 🗸 Natural 5 Pending 1 Yes 2 No filled in by the 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State determined

PA

Death

Year

2 No

29d. Date signed (Month, Day, Year)

May 16, 2012

Division

10V

31. Date filed (Month, Day, Year) State Registra

29b Signature and title of certified

Victor Weedn MD JD

Homicide

r's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

OCME

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only)

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra amend 8 per ab g934 12/14/12 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Baby Girl Nelson Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth /2/12 **Funeral** 1 □ M 2 🂢 F Months Hours **Director** infant Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 5928 Kavon Avenue 21206 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 X Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Myeshia Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Loch Raven Blvd Baltimore, MD Good Samaritan Hospitsl 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ★ Other (Specify) in state Sig outre of Funeral S rvice Licensee 22. Name and Address of Facility Antomy Board 655 W. Baltimore, MD 21201 Directoe Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Preterm Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. (Disease or iinjury Due to (or as a consequence or, attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ► No Pregnant at time of death Month Day Year ed by the a 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performe certificate 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funer. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Kathleen L. ShafferMs D0062689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 15ay ŽÖ12 01son 6:00 P M Α. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birfh (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 032-05-9744 1 🛛 M 2 □ F 94 Yrs Jan. 4, 1918 Massachusetts Usual Residence of Decede irel", or items 23e or 28e-f show Examinar must be notified at flied within 72 hours efter deeth with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director Barnstable Dennis Port 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Longell Rd. 02639 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian 1 ☑ Yes 2 ☐ No If Yes, Give W W II Year or Dates. W W II Black. White, etc. ģ 1 Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "neturel", Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Teacher Education it. Pege 1 end 2 should be filed witl rtment of Health end Mentel Hygler rtent: If item 27 is merked other i njury or other treumetic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Car1 01son Algot Anna Alice Mansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanore Olson / Wife Longell Rd., Dennis Port, MA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pege 1 e Depertment of I-Importent: If ite eny injury or ot Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State Chesapeake Crematory | 05/18/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD ²² Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 2 . Signature of Funerat Se 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CEREBRAL ARTERY ACCIDENT Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signed by the ettending physicien end d be deteched for use es the burial-trensit or Attending Physicien: The lew requires thet the deeth certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hoepitel or Attending reserved within 24 hours efter death.

To the Funerel Director: After this certificate has been significate has been significate has been significate by the funeral director, page 2 should be 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6XXXOther (Specify) 1 ☐ Yes 2 🛣 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Investigation 1 🗌 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar

only one)

29b. Signature and title of certifie

DEBORAH MILLER CRNP,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 MUNCASTER MILL RD.

32. Register's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

ROCKVILLE, MD

5.15.12

20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month renn 0618 AM May Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 9-2-1936 1 M 2 D F Director 75 MD 10c. City, Town or Location 10d. Inside City Limits death with the Maryland must be notified at Completed by Funeral Director 28a-f 1 Yes 2 No ō 10f. Zip Code 10g. Citizen of What Country? 23a 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces' or Black White etc. Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify. Black "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
fa. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) Cylege (1-4 or 5+) tudia Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ဂ္ tenn Informant's Name/Relationship (Type, Brint Important: If item 27 is any injury or other traconce. *Viece* 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) n ture of Funeral Service Lice is e 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 21 luce dire Amylaidane Fulminant Medical Due to (or as a consequence of): Examiner ence Sequentially list conditions. Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Acute renal physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Pregnant at time of death Day Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 1065718 May 15, 2012 Pendli itte MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PENDLI ,2401 West Belvedere Ave Baltimore MD 21215 HARITHA MO 32. Registrar's Signature 31. Date filed (Month, Da State NAY 1 8 2012 Registrar

David Michael 12-03594 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 2012 | 5871 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ David Michael Parks Month Day May 10, 2012 **Medical Examiner** 0950 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death 6315 Eastern Avenue & Kane Street **Baltimore** 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** unk Days Months Director 50 10/17/1961 MD 1 XM 2 F Country) Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location MD Baltimore Essex 1 Yes 2 XNo or 28a-f show 1. Pages I and 2 should be filed within 72 hours after death with the Maryland function of Health and Mental Hygiene.
rfant: If item 27 is marked other than "natural", or items 23a or 28a-f she y or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 305 Maple Ave 21221 USA uneral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1X Yes 2 White If Yes, Give Yeer 1981-82 3 Widowed 4 X Divorced 1 Yes 2X No specify: Specify: ੬ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 12 yrs Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence Parks Shirley Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Parks Mother 305 Maple Ave Essex MD 21221 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Atlantic Crem 05/14/12 Glen Burnie MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signal of Funeral Service Lice ThomasAllenPA 7090 Ridge Rd Hanover MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and Medical Death a Alcohol and Heroin Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 30 Hospital or Attending Physician: The law requires that the death certificate be executed g physician and the burial - trans Physician/Medical AMENDED 23a, 27, 28a-f, per me, g927 5-21-12 sm ■ UNPENDED Box 68760, IF FFMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month use as t Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗸 Other Scene this 1 V Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural 1 Yes 2 X No unknown 5 Pending death. Director: in by the fd 5-10-12 fd 09:45 am 2 Accident To the Hospital or Att within 24 hours after de To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 500 Kane St. Baltimore, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be Railroad Tracks (Specify) Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

adra

State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Carol Allan, MD

llau

OCME

Registrar

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

May 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 16, 2012 9:52 а м Carl W. Palmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Glen Arm 4410 Breidenbaugh Lane If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 79 212-32-1454 Director 1 🖾 M 2 🗆 F Maryland Dec. 18, 1932 Usual Residence of Dec or 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Baltimore Glen Arm 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? by Funeral 23aU.S.A. 4410 Breidenbaugh Lane 21057 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces?
1 ☐ Yes 2 ☐XNo Black, White, etc. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Black & Decker 12 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Madeline Bull Wade Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 27 2102 Laurel Brook Road, Fallston, MD 21047 Mary Hall-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 X Burial 2 Cremation 3 Removal from State Church of the Brethren 5/19/12 4 Donation 5 Other (Specify) Long Geen, MD 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 1050 York Rd.. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Mara Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical as the attending IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify,

Box 68760 P.O. Records, this certificate Division of Vital

the funeral director, e Hospital or Attending P n 24 hours after death. e Funeral Director: After t

1 Yes 2 100 ပ 27. Manner of Death Medical Certificate: 1 Natural Accident

29a. Certifier

(Check

only one)

28a. Date of injury (Month, Day, Year) 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number DITTO

28c. Injury at work?

1 Yes 2 No

М

29d. Date signed (Month, 20 T

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

30. Name and address of person who complete

State Registrar

To the I within 2 To the I

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Month May 2012 Year T. Ryder 0353 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson MD Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 VA 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** March 15, 1935 215-30-7859 Days Hours Min Director 1 XM 2 □ F 77 Yrs Usual Residence of Decedent 10a. State 10b Count 10c. City. Town or Location rei", or items 23a or 28a-f sho 10d. Inside City Limits Director Baltimore Middle River 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7209 Oliver Beach Road 21220 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: "naturei" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired),
Steel Worker al Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Beth Steel Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) t. Pege 1 and 2 should be filed tment of Health and Mental Hi tant: If item 27 is marked ot ည Charles Ryder Ryvers Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Buford /daughter Oliver Beach Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State permit. Pege 1 a
Department of H
Important: if ite
any injury or ott tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MeadowridgeCemetery 5/19/12 Baltimore MD 4 Donafion 5 Other (Specify) 21. Sign tur Funeral Ser 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fhysician/ Branchogenia disease or condition t yours Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Dending iniury 1 Natural 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 定 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 | 3 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

OV

State Registrar 670

MARIES

32. Registrar's Signature

1 8 2012

			Please	Type or Print in					_		gible.	
			For State Registrar	State of Marylar		artment o <i>tificate o</i>				liene Reg. No. 2	012	15874
	Physicia Medic		1. Decedent's Name (First, Middle, Last) John E Roberts						2. Date of Dear Month 05/12	th	Year	3. Time of Death 8:00a M
	Examir		4a. Facility Name (if not institution, give s Casey House	treet and number)		4b. City, Tow Rock		of Death			y of Death	ery
	Funeral Director		5. Social Security Number 6. Sex 213-42-6622 Usual Residence of Decedent	7. Age (In yrs.)	ast birthday) Yrs.	If Under 1 You Months Da	ear If Underlys Hours	er 24 Hrs. Min.	8. Date of Birth 1 (Month, Day,		9. Birthp Coun	olace (State or Foreign try) MD
	Maryland 28a-f ahow offied at	irector	10a. State 10b. County MD Montgom		y,Town or Lo Rockvi						1	0d. Inside City Limits 1 ☐ Yes 2 No
	s 23a or	Funeral Director	10e. Street and Number 12113 Portree	Drive		10f. Zip Co	20852			10g. Citizen of	What Cour	ntry?
9036	e filed within 72 hours efter death with the Maryland tel Hyglene. ed other than "natural", or items 23a or 28a-f ahow event, the Madical Examiner must be notified at	<u>۾</u>	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Was Decedent If Yes, specify (Cuban, Mexic	an, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ack, White, o y: Wh	
1215-0	ithin 72 hou lene, r than "natu the Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Ockind of work do	ne during mo	ost of workir	ng	16b. Kind of I		dustry
Maryland 21215-0036	should be filed wit n and Mentel Hygle 7 ia marked other raumetic event, #	To Be C	10 yrs 17. Father's Name (First, Middle, Last) John Henry Robe	rts	_ мес	hanic	18. Mot	ther's Name	(First, Middle, I ce Gert	Maiden Surnan	king Park	s
, Mary	parmit. Page 1 and 2 should be f Department of Health and Mente Importent: If item 27 is marked any injury or other traumetic a once.		19a. Informant's Name/Relationship (Type Melvin E. Rober						Route Number,			
Baltimore,	Page 1 ar tment of He tent: If Iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ i 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crer clanti	osition (Name o matory or other .C Crei	place) N	05/1	4/12	20c. Location	Burn	ie MD
Bal	Depar impor any in		21. Signature of Funeral Service License	th								Fun Serv HanoverMi
	Pnysician/ Medical Examiner	0 10	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the deale cause on each line. a. Chronic Ob Due to (or as a consect	struc							Approximate Interval Between Onset and Death
100 Oly	ata be executed ohysiclan and the buriel-trensit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.								
Box 68760	To the Hospital or Attending Phyalcien: The law requiras that the death certificata be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buried.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3 L	☐ Ectopic preg ☐ Other (specil				1	ate of deliv	ery Day Year
ls, P.O.	uiras that the dea n signed by the a uid be detached i	ed by Pr	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	underlying caus	e given in Pa	rt I.				he cause of death?
Division of Vital Records,	The law requira: ate has been sig page 2 should b	Completed by						-	24a. Was a autop perfor	an 24b sy rmed? 2 XNo	. Were auto prior to co death? 1 \(\sum \) Yes	psy findings available impletion of cause of
ta	yaicien: 7	Be	25. Was case referred to medical examiner?	lospital:		2	6. Place of D		only one)			
ί	Phyai this c	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of injury	ER/Outpatie		Other: 4 Injury at		me 5 Resid			CaseyHous
on o	anding Ph. sath. vr. After thi he funerai	licate	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury		work? 1 ☐ Yes 2	1				
Divisi	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the I	al Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At In building, etc. (Special	ý) 				City or Tow	n, State)		l Route Number,
	the Hosp in 24 ho the Fune	Medical	(Check 2 Medical Examir only one) 3 Certifying Norse	cian: To the best of my knowner: On the basis of examination Practitioner: To the best of	on and/or inves	stigation, in my	pinion, death	occurred at	the time, date a	nd place, and c	ue to the ca	use(s) and manner stated.
	vith con		29b. Signature and title of certifier				ense numbe			29d. Date sign 5 / 1 2	ed (Month, /201	
	à		30. Name and address of person who co				60	1 77	. In	- D C	20	017
	Sta	te	Bindu C. Josep 31. Date fled (Mpnn Den Xar)	h 1160 Varr 32. Regis ar's Sig	um NE	<u>ST St</u>	e U2	ı was	mingto	<u>л Б.С</u>	. 201	<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 17,2012 SAMUEL C. RUBINO 12:50 A.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death STELLA MARIS TIMONIUM BALTO. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min (Month, Day, Year) Director 214-20-1874 1 【XM 2 □ F 84 Yrs 6-2-1927 MARYLAND Usual Residence of Decedent 28a-f shov 10b. County Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 TNo MD. BALTO. KINGSVILLE ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7508 BRADSHAW ROAD 21087 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify. "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I 7TH SALESMAN FOOD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be filk th and Mental F. မ THOMAS RUBINO KATHERINE SCANDILATA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH L. RUBINO SON 7508 BRADSHAW ROAD KINGSVILLE, MD. 21087 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MOST HOLY REDEEMER 5-19-2012 BALTIMORE, MD. 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. of Funeral Service License 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ock, or heart failure. List only one cause on each line Immediate Cause (Final et and Death Physician/ Drg.e Q11 disease or condition resulting in death) Medical Due to (or as a c nsequence of **Examiner** etws sevio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has RUBINC page 2 autopsy performed this certificate 2 🔀 No Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending SAMUEL iours after death.

Interest of the filed in by the fu 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certil 29d. Date signed (Month, Day, Year) 3 lay 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

ERNESTINE WRIGHT,

18

31. Date filed (Month, Day, Year)

 $M \cdot D$.

2300 DULANEY VALLEY ROAD

21093

MD

TIMONIUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Jonstance Robinso	1- For State Certificate of Death Reg. No.	01
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year	h
wedical Examiner	Constance Robinson May 4, 2012 Of 42 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	6269 64th Avenue #4 Riverdale Prince George's	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Washing Country) 9. Birthplace (State or Foreign Washing Countr	ton
any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City	
Aaryland 28a-f show 1 at once. ector	MD Prince George's Riverdale	No X
the Maryland or 28s-f sh iffied at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6269 64th Avenue #4 20737 USA	
er death with the continue of the continue the notion of the continue the continue of the cont	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. White, etc.	ζ,
s after deat ral", or ite ainer must by Fun	Armed Forces? 1 Yes 2 No White, etc. White, etc. White, etc. White, etc. White, etc. White, etc. Yes, Give Year or Dates: 1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Specify: black	
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5-0036 ed within 72 hour 19/9giene. other than "natu the Medical Exart Completed	8 0 cook food service	
15-0 iled wi Hygien forher		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica To Be Comple		
MD 12 shouth and 27 is a 27 is turn at 1	Charnelle Savoy/daughter 4927 Glassmanor Drive #301 Oxon Hill, MD 207	45
nore, ages l and nt of Heal t: If iten other tra	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Structure of Funeral Struc	
Physician	Baltimore, MD 21201 23a. Pak I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate In	
/Medical Examiner	failure List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease Death	et and
	or condition resulting in death) Due to (or as a consequence of):	
iner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
60, ate be executed thysician and eburial - transit	MENDED 23a,pt.II,27,per me,g927 5-21-12 sm	\neg
OX 68760, eath certificate be exc attending physician a for use as the burial -	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Yea	ar
h. Box 687(the death certifica by the attending ph ched for use as the	past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	
O. B at the d of by the tached f		:h?
S, P.O. uires that the signed by id be detacled by Federacled by Federac	Chronic Obstructive Pulmonary Disease, Obesity	
Records, The law requires freate has been sig , page 2 should be	24a, Was an 24b. Were autopsy findings ava 24b autopsy prior to completion of cause 24b autopsy prior to completion of cause 24b autopsy prior to completion of cause 24b autopsy findings ava 24b autopsy prior to completion of cause 24b autopsy prior to completion of cause 24b autopsy findings ava 24b autopsy prior to completion of cause 24b autopsy prior to cause 2	
ifficate		No
Vital F ysician: this certific director, 1	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other: Scene	
Division of Vital Records, tal or Attending Physician: The law require is after death. In Director: After this certificate lass been sited in by the funeral director, page 2 should be rification: To Be Completed	27 Manner of Death 28s Date of Injury 28h Time of Injury 19sc Injury at Work2 28d Describe how injury occurred	
isior Attend r death ector: by the	Natural 5 Pending 1 Yes 2 No Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number)	r. City
Division o septral or Attending hours after death. Ineral Director: After the properties of the prope	Suicide 6 Could not be determined 4 Homicide Could not be determined (Specify)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate las been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E.		
M N N N N N N N N N N N N N N N N N N N		
	O.C.M.E. May 5, 2012	
	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State		
Registrar DHMH 17 Rev 1/2001	ORIGINAL	
	OCHE ORIGINAL	

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 64

	_	Registrar cedent's Name (First, Middle, L	Last)		Cer	tificate of I	Death T	2. Date of Dea	Reg. No.	201	2 158 3. Time of Deat
in/ cal		thleen Marler						May		2012 ^{ar}	3:50 A
er		acility Name (if not institution, g .lchrist Center	,	ce		4b. City, Town, o	r Location of Death			County of Deat altimor	
	21	ial Security Number 4-50-2603 Residence of Decedent	. Sex 7. Ag	ge (In yrs. last 65	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl 1 0 1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	946		thplace (State or For unit) and
Director	10a. S		ore		Town or Loc	cation					10d. Inside City Lir
	10e. S	Street and Number		1		10f. Zip Code	.1221		10g. Citiz	zen of What Co	ountry?
ed by Funeral	11. Ma	arital Status Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Armed Forces?		l1	Vas Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R			14. Race - Ame Black, White	rican Indian,
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	ı	Informant's Name/Relationship				-	and Number or Rural Point Road				
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al Examiner	if any cause that in	ventially list conditions, v, leading to immediate e. Enter Underlying ve (Disease or finjury mittated events ting in death) Last	b. Due to (or as		nce of):						
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Schmidt Florence Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CLEM AMNIE NTR Social Security Number If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year **Funeral** Days Months 214-40-1140 Director 1 🗆 M 2 🐴 F 68 8/20/1943 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 37 Thomas Rd. 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces' permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify If Yes, Give Specify: White 3 □ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Homamaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Siegert. Sophie Rietter Edward schmicht. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Thomas Rd., Glen Burnie, MD 21060 Bonnie Arrington (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 5/21/12 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between -8515 Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine FULMONARY Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and BOTELLTIME Division of Vital Records, P.O. Box 68760 CC burial-tran resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has page 2 autopsy 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Gleu Burnie my 20161 801 HEC pital rue 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Month **MAY** 8:07 AM 13 SHEPHERD ALBERTA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** year) 1922 Hours Min SEPT • 6 237-20-8690 NORTH CAROLINA 1 🗆 M 2 💢 F Director 89 Usual Residence of Deceder or 28a-f show notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 □ No PRINCE GEORGE'S HYATTSVILLE MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 20784 3810 COOPER LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ ☐ Yes 2 🔀 No Maryland 21215-0036 BLACK If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT 6TH CUSTODIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ NONER WILLIAMS other traumatic WILLIE BAGLEY uege 1 and 2 sk.
Uegartment of Health an
corant: If item 27 is n.
an injury or othor. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 COOPER LANE HYATTSVILLE, MARYLAND 20784 WILLIE SHEPHERD/HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State LINCOLN CEMETERY 5/19/2012 BRENTWOOD, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, INC. ture of Fervice Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown signed by t Part II. **Other** s<mark>ignificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗌 No Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 05-13-12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Almino

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

racks

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012RAYMOND SEEWAI MAY Medical 8:25 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4701 SHERIDAN STREET RIVERDALE PRINCE GEORGE'S Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months (Month, Day, Ye AUG. 30 Days Hours Director 060-82-0274 68 1 X M 2 🗆 F TRINIDAD 1943 28a-f show with the Maryland 10a, State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits PRINCE GEORGE'S RIVERDALE Yes 2 No 0 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? 23a Funeral 4701 SHERIDAN STREET 20737 USA items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White etc TRINIDAD or, þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural" Completed 3 Divorced Specify: Year or Dates er than "natur the Medical (15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) POLICE OFFICER GOVERNMENT other Be 17. Father's Name (First, Middle, Last) of Health and Mental Hitem 27 is marked of other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၉ EMMANUEL NOLASCO SEEWAI IVY 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4701 SHERIDAN STREET RIVERDALE, MARYLAND 20737 MAGDELENE SEEWAI/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō ± 5 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury or RIVERDALE CREMATORY 5/14/2012 RIVERDALE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Emer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition Physician/ Onset and Death CAPDIAC APPEST Medical resulting in death) Due to (or as a consequence of) Examiner FENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 2 No the 9 🗌 Unknown 9 Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Yes 2 X No 2 \square No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injun Accident
Suicide Investigation 1 Tes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my including a dath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) MD DO 9357 MAY 8, 2012

Registrar

State

5804 BALTIMORE AVENUE HYATTSVILLE, MARYLAND 20781

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signat

RICHARD LILY M.D

31. Date filed (Month, Day, Year)

MAY 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. 101	State of Marylan				/lental Hyg	jiene		g pas	
			State Registrar		Cer	tificate of E	Death		leg. No. 2	112	5	881
	Physicia Medic		Decedent's Name (First, Middle, Last) FABIA	ELAINE		SMITH	H	2. Date of Deat Month MAY 1	Dav	Year	3. Time of 2:57	f Death
	Examin	er	4a. Facility Name (if not institution, give stre 2009 TREETOP L	,			Location of Death		4c. County		ПООМЕТ	227
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthpl	GOMER ace (State o	
	Director			м 2 X F 54	Yrs.	Months Days	Hours Min.	(Month, Day,		GEORG		
	and show at	o	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation					d. Inside Ci	ity Limits
	Maryla 28a-f stified	Director	MD MONTGOMER	Y SI	LVER S	PRING					1 X Yes	s 2 🗌 No
	th the	ralD	10e. Street and Number 2009 TREETOP LANE	#21		10f. Zip Code 20904	<i>.</i>		10g. Citizen of V	What Count	ry?	
	ems 2	Funeral		. Was Decedent Ever in U.S	3. 13. V		ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No-	14. Rac	e - America		
36	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		Yes, specify Cuba		Rican, etc.)	Blac Specify	ck, White, e	tc. LACK	
0	hours a	letec	3 X Widowed 4 □ Divorced 15. Decedent's Education		16a. Deced	ent's Usual Occup	ation		16b. Kind of B		ustrv	
212	nin 72 l ne. han "r e Med	Completed	(Specify only highest grade (Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired)	during most of work	ing			,	
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Maryland 21215-0036	should be filed and Mental Hy is marked oth aumatic event	인	ROBERT BRASWELL				LAVERNE	BUGGS		=/		
lary	should and Me is mar raumati		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street a	and Number or Rura	al Route Number,	City or Town, S	State, Zip Co	ode)	
	1 and 2 should be if Health and Men item 27 is marke other traumatic		JAMACIA SMITH/DGT 20a. Method of Disposition			TREETOP sition (Name of	LANE #21	SILVER Date	SPRING.			20904
mor	- O - b-		1 X Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	emetery, cren	natory or other plac	ERY 5/19		BRENTWO			ID
Baltimore,	permit. Page Department Important: I any injury o once.		21. Signature of Funeral Service Licensee	11	22	. Name and Addres	ss of Facility J.	B. JENK	INS FUN	IERAL	HOME,	INC.
	TD = 40		23a. Part 1. Enter the disease, or complica	Llower tions that caused the eath							Approximat	
1	Physicani		shock, or heart failure. List only one c Immediate Cause (Final disease or condition	DIABETES ME	פונידדדו						Interval Bet Onset and I	
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):							
		Jer	Sequentially list conditions, b. if any, leading to immediate	CORONARY AR'		ISEASE						
	uted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	HYPERTENSIO	N							
	ite be executed hysician and the burial-transit	dical E	resulting in death) Last	Due to (or as a consequ	ence of):							
3760	ficate I g phys as the	Medic	d.									
Box 687	th certifical tending ph or use as th	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnal	I death 3		ру —			te of delive	•	Year
Bo	requires that the death certificat been signed by the attending ph should be detached for use as the	Physician/Me	1 ☐ Yes 2X No 9 ☐ Unknown	4 Pregnant at time of d 9 Unknown	eath 5 L	Other (specify)			1010	71111	Day	
P.O.	law requires that the nas been signed by the 2 should be detach	by PI	Part II. Other significant conditions contri	buting to death but not resi	ulting in the u	nderlying cause giv	ven in Part I.		bacco use cont			
rds,	equires een sig hould t								es 2 No			
Division of Vital Records,	e law r e has b ige 2 s	Completed						24a. Was a autop: perfor	sy	prior to con death?	sy findings an apletion of c	
a B	ysician: The law I nis certificate has k I director, page 2 s	Be Co	25. Was case referred to medical examiner?			26. Pl	ace of Death (Chec		2 A No	1 Yes	2 🗀 No	
Ĭ,	hysic this ce al dire	၉	1 ☐ Yes 2X No	pital:			4 U Nursing Ho	ome 5 X Reside				
n O	ding F th. After i	cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work M 1	yat (? Yes 2 🗆 No	28d. Describe ho	w injury occurr	ed		
/ISIO	r Atter er dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre			28f. Location (St City or Town		er or Rural I	Route Numb	be <i>r</i> ;
á	pital or		A A CONTACT OF THE CO			1 -4 41 - 41	- Indiana di aliana				_	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2 L Medical Examiner:	n: To the best of my knowl On the basis of examination ractitioner: To the best of m	and/or invest	igation, in my opinic	on, death occurred a	t the time, date ar	id place, and du	e to the cau	se(s) and ma	ınner stated.
	withi To th	_	29b. Signature and title of certifier	0.000		29c. License	e number	2	29d. Date signe	d (Month, D	ay, Year)	
	i e		Detalled as		220\ /Ti == -	D434	196		MAY 15	, 201	.2	
	JV		30. Name and address of person who com MOHAMMAD KHALID MI	D 12001 FERRA	ARA AVI		TON, MAR	YLAND 20	906			
	Sta Registra	e	31, Date filed (Month, Day, Year) NAY 1 8 2012	32. Registrar's Signat	TO SERVICE AND ADDRESS OF THE PARTY OF THE P							
	negistr	31	4444									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me,g927,05/17/2012dhb
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Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) **Director** 20-46-9455 1 X M 2 □ F 05/03/1957 55 Usual Residence of Decede 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 Yes 27 No REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12321 DIPLOMA DRIVE 21136 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 KMarried ል Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BANKER BANKING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of 2 SHAIVITZ **SELMA** SUSSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health ar Important: If item 27 Is any Injury or other treu once. JAN COHEN/WIFE 12321 DIPLOMA DRIVE, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONGR. 05/07/2012 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Sidnature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Inset and Death Physician/ ANAPLASTI PA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): CHLEXAMINER Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death 1 Yes 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conhibute to the cause of death? ğ INTRAVONTRICULAR 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🔲 Yes Seizure 24a. Was an 24b Were autopsy findings available prior to completion of cause of has autopsy 1 🗌 Yes 2 1 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes Other: 4 Nursing Home 5 Residence 6 N Certificate: To HOSPIC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending death. ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the house to within 24 house To the Funeral Directory filled in Passely filled in hours after Medical 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie with completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

32. Registrar's Signature

7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Steigerwald William Anthony 10:23 AM May 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Stella Maris Hospice Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country)
Maryland Days Months Hours 212-34-5267 Director 1 X M 2 □ F 75 March 1,1937 Usual Residence of Decedent parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, the Medical Evan or must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Dundalk Baltimore Maryland 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21222 1710 Woodland Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2X Married ≥ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Printing Company Printer 8 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia McNamara William A. Steigerwald Sr. 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1710 Woodland Drive, Dundalk, Maryland wife Kay Steigerwald 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State May 18,2012 Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Agnature of Funeral Service Licensee Connective rufferal Home Of Dundalk, P.A. ntkonis 7110 Sollers Point Road, Dundalk, Md. 21222 Part 1. Enter the disease of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRAIN CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death cartificate be axacuted within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and complataly filled in by the Attorned infector, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events WILLIAM STEIGERWALD Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Division of Vital å 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 🛣 Other (Specify) HOSPICE 1 Yes 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe of certifie

Registrar

DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

TARIO MAHMOOD,

MAY 1 8

31. Date filed (Month, Day, Year)

5

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{1}\underline{\overset{\text{d}}{4}}$ Physician/ Streech Semones Suzanne 2012 8:38 P M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Derwood 17525 Wheat Fall Dr. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 M 2 😿 Months Days Hours Min ^{Year)}1940 June 13, 551-52-6832 71 **Director** California Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Derwood 1 ☐ Yes 2 No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17525 Wheat Fall Dr. 20855 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No er than "natural", or iter the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Retail Florist Owner / Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o Streech Agnes McDouga11 Avery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Poole / Daughter Important: If item 27 any injury or other tra 17525 Wheat Fall Dr., Derwood, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 05/17/2012 Beltsville, MD Signature of Funeval Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 933 Gist Ave., Silver Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MONTH Physician/ disease or condition resulting in death) RESTRICTIVE LUNG DISEASE Medical Due to (or as a consequence of) Examiner PULMONARY FIBROSIS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) LONG STANDING LUPUS the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2XX No
9 Unknown 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? MULTIPLE STROKES 24a. Was an page 2 autopsy The performed ATRIAL FIBRILLATION Yes 2 ▼ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2XXNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home XX Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

100

Box 68760

P.O.

Records,

Division of Vital

29b. Signature and title of certifier

CHRISTOPHER

1 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D31839

DUNFORD M.D., 615 W. MONTGOMERY AVE., ROCKVILLE, MD

29d. Date signed (Month, Day, Year)

MAY

16, 2012

20850

20 0,000 Baltimore, Maryland 21215-0036 SMITH, CARRY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Po Physician/ May 2012 2:08 A M Smith Dale Larry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 8. Date of Birth (Month, Day, Year) May 25, 1948 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Min. Months Hours 63 Idaho 518-58-0356 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director 1 Xyes 2 No 28a-f D.C. Washington D.C. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 20008 United States 4808 30th St. NW er than "natural", or items the Medical Examiner mu death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: Completed 3 ☐ Widowed 4 🏋 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Government alth and Mental Hygiene. 27 is marked other than r traumatic event, the M College (1-4 or 5+) Elementary/Seconday (0-12) Consultant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Rowl and Smith Betty Louise Eugene Leon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4808 30th St., NW, Washington D.C. 20008 Michael C. Smith / Son 27 Department of Health Important: If item 27 any injury or other the once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Emoval from State Chesapeake Crematory | 05/15/2012 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Rapp of Ameral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ myocardial acute disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death ed by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been signi irector, page 2 should be 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 ☐ Yes 2 🗭 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🔲 Yes 2 🗆 No 27. Manner of Death 28b. Time of 1 Natural 28d. Describe how injury occurred injury 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MY 72607 2012 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 101 'eterchen, MD 31. Date filed (Month, Day, Yea **KAY 1** 8 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10:55 PM 2. Date of Death Physician/ MAY 13 LEONARD A. SKOVIRA 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8728 AVONDALE ROAD BALTIMORE PARKVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Funeral Director 125-09-7466 1 🕅 M 2 🗆 F 94 OCT. 21, 1917 PENNSYLVANIA Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No BALTIMORE PARKVILLE MARYLAND 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral U.S.A. 8728 AVONDALE ROAD 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force 1 Never Married 2 Married ☐ Yes 2 💢 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE If Yes, Give Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DRY CLEANING STORE OWNER N/A 12 YEARS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ MARY GAVENDA JOHN SKOVIRA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
85 KENNEDY WADES MILL LOOP
RAPHINE, VA 24472 JOSEPH F. SKOVIRA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATION SER. 5/16/12 GLEN BURNIE, MD 21. Signature of Fune al Service Licenses SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. E. as Underlying Cause (Disease or injury Due to (or as a consequence of): Exami this certificate has been signed by the attending physician and stal director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical SKOVIR Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2**X** No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy Hospital or Attending Physician: The Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accident injury 5 Pending Investigation 24 hours after death Funeral Director: 6 Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one within To the 29b. Signature and t 29d. Date signed (Month. Day, Year, 30. Name and a use of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State o	f Maryland		ırtment of H		and M	ental Hyg	jiene	010	15007
		1	State Registrar			Cer	tificate of L	Death		F	leg. No.	012	12881
	Physicia	n/	1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month May	_	201°2	3. Time of Death
	Medic	ai -	Haven E. Simm		t - 3				(Devile	May			6:00 P ^M
4	Examin	er '	4a. Facility Name (if not institution,		Der)		4b. City, Town, o	cott (4c. County	ward	
	Funeral		9306 Mist Haven 5. Social Security Number		7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	1	9. Birthp	ace (State or Foreign
	Director		484-20-5858	1 🗶 M 2 🗆 F	00	Yrs.	Months Days	Hours	Min.	(Month, Day		Mica	souri
	t to	_	Usual Residence of Decedent 10a, State 10b. County		89	, Town or Loc	eation			sept 20	1922		Od. Inside City Limits
	arylan a-f sh fied a	Director			135. 2,	,	Elli∝	tt Ci	+17				1 Yes 2 XNo
	or 28		MD Howa 10e. Street and Number	ru			10f. Zip Code	CC CI	Су		10g. Citizen of	What Coun	ry?
:	s 23a ust b	Funeral	9306 Mist Haven	Court			2	1042			Unite	d Sta	tes
:	death item:		11. Marital Status	12. Was Dece Armed For		. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Orig an, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		ce - America ck, White, e	
950	after Il", or xamil	d by	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	9	45 1	☐ Yes 2 X No	Specify:			Specify		
3	atura ical E	Completed	15. Decedent	's Education	tes. 1941-	16a. Deced	ent's Usual Occup	ation			16b. Kind of E		
2	n /2 h	ᇍ	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-	-4 or 5+)	(Give F life. D	ind of work done NOT use retired)	during mos	t of workin	ng			
7	withi /giene her th t, the			5+		Lawy	er				Paten		
	2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, La	•						(First, Middle, I	Maiden Surnan	ne)	
3	d Mer mark matic		Haven Y. Simmon		_	Table Maritim	ig Address (Street		y E.		City or Town	State Zin C	ode)
<u>⊽</u>	2 sho Ith an 27 is : traus	ĺ	Haven P. Simmon) Allenwo						000)
บ์	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			lace of Dispo	sition (Name of natory or other pla	- :		ate	20c. Location		wn, State
	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (Sp				ney Crema		5/17	/2012	Woodk	oine,	Maryland
Daltillior	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tone.		21. Sign to e of Funeral Service Li	tensey/	1/2						ce P.O.	Box ville	784 , MD 21029
			23a. Part 1. Enter the disease, or o	complications that of	aused the death								Approximate
	hysictan/		shock, or heart failure, List or Immediate Cause (Final disease or condition		astatic	Carci	bion						Interval Between Onset and Death
	Medical		resulting in death)		or as a consequ		LIDIG						
	Examiner	<u>.</u>	Sequentially list conditions,	b. ———									
	sit sit	nine	if any, leading to immediate Cause (Disease or injury	Due to	or as a consequ	ence of):							
	and and al-tran	Exal	that initiated events resulting in death) Last	c Due to	or as a consequ	ience of):							
2	sician sician burit	cal		d.									
0/0	mcate ng phy as th	Med	IF FEMALE:					-					
DOX 001	n cert tendir or use	an/l	23b. Was decedent pregnant in the past 12 months?	1 Live		Ideath 3	Ectopic pregnan	су				ate of delive	ery Day Year
0	e deat the at hed fo	Physician/Medical Examiner	1 Yes 2 No 9 Unknown	4 ☐ Preg g ☐ Unkr	nant at time of d nown	leath 5 L	Other (specify) _				1	OIIII	Day Toui
л Э	at the ed by detac		Part II. Other significant conditio	ns contributing to d	eath but not resi	ulting in the u	inderlying cause g	iven in Part	1.	23e. Did to	bacco use cor	tribute to th	e cause of death?
ν.	irres tr signé ild be	d by	Prostate Cancer							1 🗆 '	Yes 2 🔀 No	3 Prob	oably 4 🗆 Unknown
Records,	v requ	ompleted								24a. Was			osy findings available mpletion of cause of
ec F	he lav Ite has page 2	mo.								autop perfo 1 Yes	rmed?	death?	
Vital	ian: I	Be C	25. Was case referred to medical examiner?	11 321				lace of Dea	ath <i>(Check</i>				
5	hysic his ce al dire	은	1 🗌 Yes 2 🔀 No		Inpatient 2			4 L N	1	me 5 🛭 Resid			
10	ling P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	∮ `	th, Day, Year)	28b. Time of injury	wor		- 1	28d. Describe h	ow injury occu	rred	
SIOIS	death ctor y the	Certificate:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be	of Injury - At ho	me, farm, str	eet, factory, office	163 2		28f. Location (S	Street and Num	ber or Rural	Route Number,
DIMISION	al or / s after I Dire		4 🗆 Homicide determi	buildi	ng, etc. (Specify)				City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aftr death. within 24 hours aftr death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical E	Physician: To the b	sis of examination	n and/or inves	tigation, in my opin	ion, death o	occurred at	the time, date a	nd place, and d	ue to the car	use(s) and manner stated.
	the lithin 2 the long	Me	only one) 3 Certifying 29b. Signature apd title of certifier	Nurse Practitioner	r: To the best of n	ny knowledge	, death occurred at		ate and pla		he cause(s) and 29d. Date sign		
	F ≥ F ŏ		10000	. 12	Sen			71600			5/1	5/12	
ic	×1.		30. Name and address of person v	vho completed caus	se of death (Item	23a) (Type, F					1.	-	
0	x 1		Tejaswi R. Sas	ry 1071	0 Charte	er Dri	ve Columb	oia, M	MD 21	044			
	Sta Registr		31. Date filed (Month, Day, Year)	2 2019 32.5	gistrar's Signat	ture	are						
	negisti	e II	MM1 + C	LOIL A	many.	<u> </u>							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY Smith 00:02 am 2012 Medical 4c. County of Death **Examiner** saltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min 215-32-9919 76 1 🗆 M 2 🔏 F **Director** Oct 24,1935 Maryland 28a-f shov ms 23a or 28a-f sho must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD Howard Hanover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6054 Florey Road 21076 United States items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black. White, etc. Ь by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Howard Co. School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Edmund Feaga Eleanor Brunsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Jim Smith (Husband) 6054 Florey Road Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 Cremation 3 Removal from State 4 Dopation 5 Other (Specify) Meadowridge Mem.Park 5/18/2012 Elkridge, Maryland permit. Name and Address of Facility
ry L. Kaufman Funeral Home at MMP, Inc. Ture of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Mary land de death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the sahould be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy completely filled in by the funeral director, page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 [] 3 [] only one) 29b. Signature and little First Person who completed cause of death (Item 23a) (Type, Print)

THU TO GEBREYES, 900 Caton AVE, Balthmore, MD, 21229

Registrar DHMH 17 Rev 06-2011

State

30. Name and address

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eloise Sinquefield 11:55 AM May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard 6391 Rowenberry Drive Elkridge 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. Jan^{th,}22, ^Y1959 Maryland 53 216-72-6136 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location ElkridgeDirector MD Howard 1 🗆 Yes 2 🗓 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21075 Funeral 6158 Pine Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decede... Armed Forces? 1 ₩ Yes 2 No Black, White, etc by 1 Never Married 2 X Married 1 [X] Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Black & Decker Machinist 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UNK) (UNK) 2 19a. Informant's Name/Relationship (Type, Print) Wayne Sinquefield (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6158 Pine Avenue Elkridge, Maryland 21075 6158 Pine Avenue Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Docation 5 ☐ Other (Specify) Meadowridge Mem Park ¦ 5/11/2012 Elkridge, Maryland Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD Signature of Funeral Service Licenses 21075 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on experience of the complex of the co d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final insula lequising Physician/ Mellitus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events and the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month sate has been signed by the atte page 2 should be detached for a Year Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes 2 No Yes Yes certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be examiner? Motors Home Other: 4 Nursing Home 5 Residence 6 Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at 1 Natural injury 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar 29a. Certifier

(Check

only of 29b. Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDHMH 17 Rev 7/2009

completed

within 2.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Physicia		1- For State	-	nd / Departn <i>Certifi</i>	cate of		Ciria IVI	cittairiy	_	eg. No.	20	
	_	Registrar 1. Decedent's Name (First, Midd	ile,Last)						2. Date of Dea	ath	1.35	3. Time of Death
cal Exami		Charles John	Sluder						Month April 4, 20	Day D12	Year	1355 hrs
ķ.		4a. Facility Name (if not instituti 700 Pulaski Highway		mber)	4	b. City, Tow Havre d		on of Death			County of Dea	th
Funeral		5. Social Security Number		7. Age (In yrs. last b	oirthday)	If Under 1		Inder 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or			
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vith the Maryland s 23a or 28a-f show a	Director	10e. Street and Number 700 Pulaski	Horary #1A			10f. Zip Co	_{де} 21078			•	n of What Co	untry?
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should I and Mer	٤	19a. Informant's Name/Relation										te, Zip Code) 210
and 2 ealth a		Richard Slud 20a. Method of Disposition	er/brother	20b. Place	e of Disposit	tion (Name o	LLL Ro	oad Lo	t 35 Lo	20c. Lo	Havre	de Grace or Town, State
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hysician		23a. Part Enter the dise se, o failure. Full only one cause	r complications that ca	aused the death. Do	not enter the	e mode of dy	ing, such a	as cardiac or	respiratory an	est, shoc	c, or heart	Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disease		nsive Car	diova	scu1a	Disc	ease				Death
		or condition resulting in death)	Due to (or as a	consequence of):								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** May 9, 2012 6:00 AMM Stephen Syromi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Brooklyn Park Genesis Hammond Lane Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F 219-28-0838 80 1932 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1√2 Yes 2 □ No MD Brooklyn Park Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 613 Hammonds Lane 21225 **USA** Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: If Yes, Give Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. self employed Health and Mental Hygi em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Stephen Syromi Veronica Szabo 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel Syromi/brother 5602 Patrick Henry Drive Brooklyn, MD item 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other (Specify) in state Funeral Service Lic 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cance months **Physician** metasta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine requires that the death certificate be executed and -trar Due to (or as a consequence of) burial-1 Box 68760 physician Physician/Medical attending IF FEMALE: asn 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No certificate 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28b. Time of Injury To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

Aviation Blud Glen Burnia MD 2/06/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

18

Please Type or Print in Black Indelible Ink. Fnsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 6:04 P M ANICE 2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL ALTIMORE 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours 220-40-**Director** 1 □ M 2 💢 F 61 Yrs 06-29-1950 MD Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD BALTIMORE 1 Yes 2 ☐ No 10e. Street and Numbe ò 10g. Citizen of What Country? ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral SPENCE 21230 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural" any injury or other term. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BON SECUR Elementary/Secondary (0-12) College (1-4 or 5+) ECHNICAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and SISTEK AMILLE MD. 21216 Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔲 Burial 2 🔀 Cremation 3 🗔 Removal from State cemetery, crematory or other Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) UKKU VAUGHN GREENE FUNERAL SOUS ervi e Licensee ROAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician senteric month Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Por in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the side be detached detached g Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed Yes 2 has completely filled in by the funeral director, page 2 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No ြု 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mannet of Death 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 May 6 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hai E University Parlenny Buttinare, MD amnel 201 31. Date filed (Month, Day, Year) NAY 1 8 2012 32. Registra s Signa State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert Torpey 05 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester White Crane Drive Berlin Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) WashDC 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** Min. 1 **№** M 2 🗆 F Months Days Hours 579-22-0692 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanture must be notified at Funeral Director 1 ☐ Yes 2 X No Berlin MD Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 9 White Crane Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? I⊠Yes 2 □ No 1 Myes 2 □ No If Yes, Give Year or Dates: 1946-66 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trau once. Shirley A Torpey Wife 9 White Crane Drive Berlin MD 21811 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 5/13/12 Atlantic Crem Glen Burnie MD 4 ☐ Donation 22. Name and Address of Facility Simplicity Crem & Fun Serv of Foneral Service Licenses Thomas AllenPA 7090 Ridge Rd Hanover 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Malignant Neodosm of disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ► No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

ipital or Attending Physician: The law requires that the death certificate be executed entra after death.

eurs after death.

The law been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, of Vital Records, Division within 24 hours a

Baltimore, Maryland 21215-0036

Medical State Registrar

determined

MO

and manner stated.

10445 Old Octave City

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

Milla Gibbs,

31. Date filed (Month, Day, Year)

MAY 1 8 2012

29a. Certifier

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DOCG6169

Bust #1, Berlin MO 21811

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Baby Girl Thomas Medical Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death saltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days May 7, 2012 1 M 2 X F Hours 45 Maryland Director infant Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director tX☐ Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a the Medical Examiner must be Funeral 616 N. Ellwood Avenue 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married à 1 ☐ Yes 2 X No Specify: black If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Tim Curbeam Shinika Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 21287 1800 Orleans Street Baltimre, MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state o, Director Signature Funeral Service Licensee ROnald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Xtre disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ပ 1X Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Accident X Naturai (Month, Day, Year) 5 Pending s after death. 1 Yes 2 No Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral D Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 30. Name and address of person v death (Item 23a) (Type, Print) Baltmore 31. Date filed (Month, Day, Year) State MAY 1 8 2012 Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Vital

Division of

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 **Physician** Darlene Frances Vallinas May 16, 1:15 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Brooklyn Park 121 Haile Avenue If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 □ M 20XF 217-52-7032 Director 63 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f show Exercited must be notified at 1 ☐ Yes 2 ₩ No Director Brooklyn Park Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 USA 121 Haile Ave. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.
ent: If Item 27 is marked other than "natural", or item ury or other traumatic avent, the Manical Exercit at 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) Coflege (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John Walter Clark Carolyn Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Vallinas, Sr. (Husband) 121 Haile Ave., Brooklyn Park, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ♣ uriai 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 5/18/12 Baltimore, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part1. Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) (au /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 NO 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 22 No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a, Certifier (Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMMOUDS FENT 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 15, Physician/ 2012 6:02 A M Russell Valenstein Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia () Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Days Hours Min. 216-28-1020 1 🗆 M 2 🕱 F **Director** 03-05-1930 Maryland 82 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 X No Windsor Mill MD Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ò er than "natural", or items 23a or the Medical Examiner must be Funeral 21244 United States 1920 Brookdale Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Community College Secretary permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Katherine Lockwood Charles H. Schuenemann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1920 Brookdale Road, Windsor Mill, MD 21244 Jerry R. Valenstein - spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Buriai 2 □ Cremation 3 □ Removal from State Meadowridge Mem Park | 05-18-2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral liome at 21. Signatu of uneral Serve MMP, Inc, 7250 Wash. Blvd., Elkridge,MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician) omplications disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying nding physician and use as the burial-transil Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death be detached 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔽 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performe after death.

Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be 2 No Hostice 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 \square Pending Investigation Accident 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D006063L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANE COLUMBIA 31. Date filed (Month, State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			100	partment of Health and N	Mental Hyg	jiene				
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death		Reg. No. 2 () 2	15897			
	Physicia Medic		JAMES C, WART,	YEN	2 Date of Deat	102012	3. Time of Death			
	Examin	er	4a. Facility Name (if not institution, give street and number) Northwest Hospital	4b. City, Town, or Location of Death Randallstown		4c. County of Death Baltimore				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth	9. Birt	hplace (State or Foreign untry)			
	Director ≥		216-34-5216		Dec.30		ryland			
	yland -f shov ied at	ctor	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits			
	he Ma or 28a e notifi	Director	Maryland Baltimore Gwynn 10e. Street and Number	Uak 10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2 🛣 No untry?			
	s 23a sust be	Funeral	2023 Wells Manor Avenue	21207		U.S.A.				
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto □ Yes 2 X No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	e, etc.			
15-0	72 hour n "natu ledical	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation we kind of work done during most of work	king	16b. Kind of Business/l	Industry			
212	within giene. er thar the M		Elementary/Secondary (U-12) College (1-4 or 5+)	ic Teacher]	Peabody Ins	titute			
Maryland 21215-0036	should be filed whand Mental Hyg 7 is marked othe traumatic event,	To Be	17. Father's Name (First, Middle, Last) James C. Warthen, Sr.	18. Mother's Nam Gladys	ne (First, Middle, N Martin	Maiden Surname)				
, Mar	and 2 shoul Health and tem 27 is m	ĺ		ailing Address (Street and Number or Rur. Challedon Drive, Wa						
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		1 Purisi 2 Koromation 2 Pamous from State cemetery	sposition (Name of rematory or other place) Gremation, Inc. 5-1	I .	20c. Location - City or Hanover, Mar				
3alti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Man	zullo Fi	uneral Chap	el,P.A.			
	₽. □ = e o		23a. Part 1. Enter the disease, or commications that caused the death. Do not	5009 Harford Road, E			21214 Approximate			
	Physician/	(5 A	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	n'14			Interval Between Onset and Death			
	Medical Examiner		resulting in death) Due to (or as a consequence of):							
Ĉ.	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly)							
10 mg	execute an and rial-trar	Еха	that initiated events resulting in death) Last c. Due to (or as a consequence of):							
09/	ate be physici the bu	edica	d							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of deli Month	ivery Day 'Year				
ds, P.O.	quires that the series of signed by the details and be detailed by the series of the s	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?			
Division of Vital Records,	sician: The law rec certificate has bee lirector, page 2 sho	Completed			24a. Was a autops perform 1 \(\sum \) Yes	med? prior to o	opsy findings available completion of cause of			
Vital	ysician: s certific director,		25. Was case referred to redical examiner? 1 Yes 2 I No Hospital: 1 Inpatient 2 ER/Outpa	26. Place of Death (Chec	k only one)	ence 6 Other speci	10			
n of	nding Phys th. : After this e funeral di		27. Manne of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 28b. Tim (Month, Day, Year) injured in the control of the con	e of 28c. Injury at		ow injury occurred				
ivisio	or Atter after dea Director in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (St. City or Town	reet and Number or Rur n, State)	al Route Number,			
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, deronly one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deronly one)	vestigation, in my opinion, death occurred a	it the time, date an	id place, and due to the c	ause(s) and manner stated.			
	To the within 2 To the comple		only one) 3 — Certifying Nurse Practitioner: To the best of my knowled 29b. Signature and title of certifier	29c. License number	2	gd. Date signed (Month	, Day, Year)			
•	5		30. Name and address of person who completed cause of death (Item 3a) (Typ	e, Print)	-1 1	la 15 .	212			
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrary Signature	him Blud O	Yen 13	4 earp	1001			
	Registra	ar	MAY 1 8 2012 Depur B. Again							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15. Cheston Wenschhof Witherow May 2012 6:30 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House 6. Sex Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 178-22-8877 Director 1**XX**M 2 □ F 84 Yrs May 7, 1928 Maryland 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ner must be notified XX Yes 2 🗆 No MD Carroll Lineboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 U.S.A. 5104 South Church Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2AXNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. 1 Never Married 2XXMarried by Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Ad within Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien ? is marked other the llth Mill Wright Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Stewart Cheston Witherow Helen Gladys Wenschhof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) age 1 and 2 s nt of Health a t: If item 27 i Erma A. Witherow (Wife) 5104 S. Church St., Lineboro, MD 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State netery, crematory or other place)
Faiths Crematory
& Chapel 1 Burial 2XXCremation 3 Removal from State Department of Important: If any injury or All 5/21/2012 Manchester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun 1 2 ryice License 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr., Manchester, MD 21102 Enter the disease, or complicate that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each ine Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam or Attending Physician: The law requires that the death certificate be executed and -trar that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Box 68760 as IF FEMALE. nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months? Dav Pregnant at time of death 2 🗌 No the 9 Unknown 9 John John Gown g Part II. Otter ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate | Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Tyes 2 1 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No Accident Suicide Investigation M 6 Could not be 3 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifie certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Medica Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 15899 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year O { Elizabeth 6:11 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13260 Treadelphia Rol Ellicott City Ho wera 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗷 F (Month, Day, Year) 8-Months Days Min Berlingham WA 9 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Elliceti 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Tradelphia RC 21042 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) u.s. government SECRETARY executive Be 18. Mother'ş Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) llam Mar ည G10045 19a. Informant's-Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Linda Duterneld inter, Tradelphia Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of TED cemetery, crematory pr other place) 1 Burial 2 Cremation 3 Removal from State Arlington Jationell 4 Donation 5 Other (Specify) 22. Name and Address of Facility any inj 21. Signature of Funeral Service Licenses MD Ellicott Meston 13260 madel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ PNEUMONIA Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical 68760 nding p IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Day 5 Other (specify) Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy 1 Yes 2 No Yes 25. Was case referred to medical of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? Division within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0069962 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAQVI 6334 CEDAR LANE, COLUMBIA, 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State MAY 1 8 2012 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#22perFH, G927,5/1872012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Seasons Hospice & NW Hospita randallstown Baltimore 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Director 1 M 2 🗆 F 86 28a-f show 10a. State 10c. City, Town or Location the Maryland items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director Baltimore MD Bandallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral South green Hoad USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) American Smelding College (1-4 or 5+) Elementary/Secondary (0-12) 11th grade Metal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Williams Kearney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Southareen Road Rundallstown MD 211 Williams/WIFE - lorarene 20a. Method of Disposition 20b. Place of Disposition (Name of-Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 19/2012 Trbutus Memorial altimore, MD Vaugho C. Greene & Funeral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Acad Chandallstown MD 21133 23a, Part 1, Enter he di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between Onset and Death shock, or h art failure Immediate Cause, Final disease or conditionesulting in death) Physician/ mone Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed ase of injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy for 5 Other (specify) Day Month 4 Pregnant a Pregnant at time of death Year detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dinknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy perform Yes filled in by the funeral director, 25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at injury 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year,

1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAT 2012 Medical County of Death n, give street and number) Facility Name (if not institute 4b. City, Town, or Location of Death **Examiner** EDICA Social Security Number 6. Sex If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In **Funeral** Hours Min (Month, Day, Year)
Jan 07, 83 West Virginia 187-26-6025 1929 1 🗆 M 2 🔀 🔻 **Director** Usual Residence of Deced 28a-f shov 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No MD Prince Georges Accokeek 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral or items 23a 20607 United States 1160 Overlook Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces? Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 'natural", 3

Widowed 4 □ Divorced Completed Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry St. Elizabeth's and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ George Brown Emma Dinkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Carole Warren /Daughter 1160 Overlook Dr. Accokeek, MD 20607 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State May 1 1 ■ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) Baltimore, Maryland King Memorial Park 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nar@rematisonFæilid Funeral Alternatives any 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Backen disease or condition mi Medical resulting in death) Examiner multiding resistant Klebsiella mosessis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse - nce of) Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death the & 9 Unknown 9 Unknown P.O. signed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 0 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 N certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 400 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

To the Fune

completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 72036 Name and address of person who completed cause of death (Item 23a) (Type, Print) LAPLata, Md. 20646 MD Towe 32. Registrar's Sign

DHMH 17 Rev 06-2011

Registrar

8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY 2012 1:00 P.M ELIZABETH JUNE WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE TIMONIUM BALTO. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Director 219-16-3792 86 MARYLAND "natural", or itams 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5511 ANTHONY AVENUE 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc \$ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) parmit. Pege 1 and 2 should ba filed with Depertment of Health end Mantel Hygler Importent: If item 27 is marked other tany injury or other traumatic event, the once. 12TH SECRETARY SHOE DISTRIBUTOR Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES PFARR FLORENCE MIRTH REYNOLDS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR DEBORAH PETERSON 6724 BRENTWOOD AVENUE DUNDALK, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 5-18-2012 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) OF FAITH 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. Signature of Funeral Service Licensee 6415 BELAIR ROAD BALTO.MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours effer death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the burial-transit Exam Hospital or Attending Physician: The law requiras thet tha daath certificate ba axecuted Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) 1 ☐ Yes 2 🕱 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title -DNP, NP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MORGAN,

TRACIE L.

31. Date filed (Mo

CRNP

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^D2012 15, 2:06 A M Wisniewski Foerster Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min (Month, Day, Year) Months Hours 218-36-9309 Director 1 M 2 X F Yrs 12-05-1938 Maryland 73 Usual Residence of Decede or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director XX Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be n Funeral 1204 Elmridge Avenue 21229 United States items 2 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. er than "natural", or iter the Medical Examiner Armed Force 1 Never Married 2 X Married Yes 2XXNo þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last and Mental 2 Department of Health and Mont. Important. If item 27 is marked any injury or other. John A. Foerster Rhoda L. Boyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1204 Elmridge Avenue, Baltimore, MD 21229 Craig E. Wisniewski - spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem Park | 05-19-2012 Elkridge, Maryland 4 Dongtion 5 Other (Specify) Ser ice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd. Elkridge, MD 21075 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Due to (or as a consequence of) Physician/Medical certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Month Dav signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy death? Il or Attending Physician: after death. 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 Other (Specify) Hospital 2. No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work?
1 Yes 2 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the h within 24 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

State Registrar 29b. Signature and little of certifier

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

6336 CESTRUANE COLUMBER, MS 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 6, 2012 10:00 AMM Jerome Wilson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number unk 6. Sex **Funeral** (Month, Day, Year) Months Days Hours Director 1 XM 2 □ F 65 DEc 5, 1946 Washington DC 28a-f show 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 😾 No DC Washington 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 0 23a Funeral 20019 718 Chaplin Street SE USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 12. Was Decedent Ever in U.Sunk 14 Race - American Indian. Armed Forces? Black, White, etc. 0 \$ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Nes 2 No Specify "natural", black Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical unk 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD 20912 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) in state Si nature Ron 1 Ways 22. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical death certificate be Box 68760 s, outcome of pregnancy Live Birth 2
Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant Unknown Pregnant at time of death the P.O. 1 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy performed Yes 2 No NDA certificate 25. Was case refe ed to medical funeral director, 26. Place of Death (Check only one) To the Hospital or Attending Physician: Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ဂ္ဂ Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral 5 Pending Accident
Suicid Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Dav. Year)

State Registrar 600

Carroll

Ave

Takoma Pack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAY 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Day Physician/ Month 9:16 PM M Edward Watkins APri1 24 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 717 Druid Park Lake Drive Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Days Mir Hours 228-58-4836 1 🛣 M 2 🗆 F Director June 7, 1944 Virginia 67 Usual Residence of Deceden shov 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at Director Yes 2 No **Baltimore** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Druid Park Lake Drive items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Deces? Armed Forces? 1 ☐ Yes 2 🔀 No Examiner Black, White, etc. ō by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify black 27 is marked other than "natural", traumatic event, the Medical Exa Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry المالية. خوا Hygiene. خوا Than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) cook unk food industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Houston Bigelow katherine Watkins 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chemisa Watkins/daughter 51st St NE #21 Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State . Page 1 Important: If it any injury or o once. 1
Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕅 Other (Specify) in state State Anatomy Board 655 W. Baltimore Street Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death the Unknown 9 Unknown á conditions contributing to death but not resulting in the underlying cau 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 perform 1 Yes 2 No Yes 2 or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 🕽 Hospita Other: 1 🔲 Yes ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending M 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person cause of death (Item 23a) (Type

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohn Russell Zulich	1- For State	St	ate of Maryl		artment of		nd Ment	al Hy		21	112	1590
Physician			e,Last) usse11	Zulick					Date of Death Month May 7, 201	Day Yea		. Time of Death 1817 hrs
	4a. Facility Name	(if not institution	n, give street and n	umber)		b. City, Town, Ellicott Cit	or Location of		Way 1, 20	4c. County of	of Death	
Funeral Director	5. Social Security 213-06-1	.780	6. Sex	7. Age (In yrs. 44	last birthday) Yrs.	If Under 1 Your Months Da	ear If Under ays Hours	24Hrs. Min.	8. Date of Birt	 h(MM/DD/YYYY -1968	9. Birthp Foreign Count	lace (State or ry) Wash.
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked atther than "natural", ar items 23a ar 23a-f show any mastic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 X Never Mari 3 Widowed	ind 2 Middle, (First, Middle,	Armed F 1 Yes orced If Yes, Give Ye or Dates: cify only highest gra College (cedent Ever in U	16a. Decedent' during mos	Sykes 10f. Zip Code 2 Decedent of F s, specify Cub Yes 2 X N s Usual Occup	1784 Hispanic Originan, Mexican, Filos specify: Dation (Give kiife. DO NOT us	nd of wor se retired	cify Yes or No- ican, etc.)	United 14. Race White Specify: 16b. Kind of Bus Const	at Country State - American , etc. V	es h Indian, Black, White Justry
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked inter it injury are other transmatic event, the Med	19a. Informant's N Bonnie I 20a. Method of Dis	ame/Relationsl Smit position Cremation Other Sp	nip (Type, Print) n — mothe 3 Removal frecify:	20b.	1 8375 Place of Disposition crematory or other lantic C 22. Na	#A Monion (Name of control on (Name of control on the control of the control on t	t gomery emetery, ry ss of Facility	er or Rur y Rur 05-1	n Rd., Date 11-12	Ellicot 20c. Location - Glen B ufman F	t City City or Too urnie unera	wn, State
of Vital Records, P.O. Box 68760, sg Physician: The law requires that the death certificate be executed and the this certificate has been signed by the attending physician and meral director, page 2 should be detached for use as the burial - transit 1: To Be Completed by Physician/Medical Examiner	Immediate Cause or condition result Sequentially list or if any, leading to it cause. Enter Und (Disease or injury events resulting in I UNPENDED IF FEMALE: 23b. Was decedent past 12 month: 1 Yes 2 Part II. Other sign	ng in death) enditions, nmediate entying Cause that initiated death) Last pregnant in the 3? No 9 Unk	a. Cocain Due to (or as a b. Due to (or as a d. AMENDED 23c. If yes, 1 Live to 4 Pregr 9 Unknown	a consequence of a consequence of a consequence of a consequence of consequence o	f): 28a-f, pe: nancy 2	r me, gg death 3 r (Specify) derlying cause	927 5-2 Ectopic p	21—12 pregnancy	23e. Did tob 1	23d. Date of o Month acco use contrib 2 No 3 No 3 24b. W proded?	lelivery Day ute to the Probable	Year cause of death? y 4 V Unknown sy findings available pletion of cause of 2 No
Division of Vital I The Hoopital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (27. Manner of Deal 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only)	2 No h 5 Pendi Invest 6 Could deterr Certifying Ph Medical Exam	ng igation not be 28a. Date (Month)	, Day, Year) -7-12 e of Injury - At ho Sing1 et of my knowledge of examination ar		DOA January 28c. Inju January 28c. Inju January 1 January 28c. Inju January 28c. Inj	yes 2 X No building, etc.	lursing H 28 0 U1 28 AI	dome 5 Rd. Describe honknown f. Location (Stror Town, State A E e to the cause(e time, date ar	s) and manner a	or Rural Fown City as stated. a to the ca	Route Number, City ountry Blue r, MD. use(s)
State Registrar		MD Ass	istant Medical	•	900 W. Baltin	nore Street	, Baltimore	e, MD 2	21223		-	

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himing Zhang		State of Maryland / Department of Health and Mental For State Certificate of Death	Hygiene	. No. 2 N	12 1590				
Physicia	1/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death Month	Day Year	3. Time of Death				
Medical Examin		Zhiming Zhang 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	April 11, 20	12 4c. County of Deal					
		214 West Montgomery Avenue Rockville		Montgomery					
Funeral Director		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	Months Days Hours Min. Warr 27 1055 Country)						
'n	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits				
daryland 28a-f show any <u>1 at once.</u>	_	MD Montgomery Rockville			1 Yes 2 X No				
Aarylai 28a-f s	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	untry? unk				
- 2 -		214 W. Montgomery Avenue 20850 11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ame	rican Indian, Black,				
eath wi	Funeral	1 Never Married 2 Married 1 Yes 2 No unk		White, etc.					
after d	요 요	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	asian				
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5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examine.	Completed	unk unk							
MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene. The marked other than m 27 is marked other than aumatic event, the <u>Medican</u>		17. Father's Name (First, Middle, Last) unk 18.Mother's Nam	me (First, Middle, M	aiden Surname)	unk				
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imore, MD 21 Pages 1 and 2 should nent of Health and Me stant: If item 27 is ma		O.C.M.E. 900 W. Baltimore St							
% & L		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State				
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	4 Donation 5 X Other Specify: in state							
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other t		Henele S. Wace, Director State Anatomy Bo	oard 655 V 21201	V. Baltimo	re Street				
Physician	1	23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
/Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death) Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death				
an and		Sequentially list conditions, b.							
	je.	if any, leading to immediate Cause. Enter Underlying Cause Due to (or as a consequence of):			_				
d sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
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60, ate be ex ohysiciar ne burial		IF FEMALE: 23c. If yes, outcome of pregnancy	-	23d. Date of delive	1				
OX 6876(eath certificate attending phy.	jan/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	gnancy	Month	Day Year				
Box 6876 e death certificat the attending phy ed for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown							
P.O. B		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol		to the cause of death?				
dS, P	Completed by		– 24a. Was a	in 24b. Were	autopsy findings available				
Records, The law require ficate has been si	all		autops perform	med? death					
Vital Records, ysician: The law requir		25. Was case referred to medical 26.Place of Death (Che	1 Yes 2	2 No 1 🗸	res 2 No				
Division of Vital tal or attending Physician: Its after death. at Director: After this certical in by the funeral director.	o Be	1 V Yes 2 No	-	Residence 6 🗸 Ott	ner: Scene				
n of V ding Phy.	L io	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occurred					
ivision or Attene after death Director:	Cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	treet and Number or	Rural Route Number, City				
Div hital or urs afte ral Dir	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, Si	tate)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and occurred at the time, da	and due to the cause ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)				
F 3 F 8	Me	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (#	Month, Day, Year)				
		Carol Hallan O.C.M.E.		April 12, 2012					
		30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223						
St Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature							
DHMH 17 Rev 1/2		ORIGINAL							

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year 26 Eleanore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 10803 Dundee Dr. Columbia Howard If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year, 6/4/1925 **Director** 568-24-7977 1 🗆 M 2 🕱 F CA Yrs Usual Residence of Decede 28a-f show with the Maryland at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director notified MD Howard Columbia 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be n 10g. Citizen of What Country? Funeral 10803 Dundee Dr. 21044 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1945 by 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 X Widowed 4 Divorced Completed 1946 Il Hygiene. other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n and Mental Hygien 7 is marked other th raumatic event, the homemaker own home Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 27 is marked r traumatic e Alfred Lidyard Katherine Webber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13712 Springdale Dr., Clarksville, MD 21029 19a. Informant's Name/Relationship (Type, Print) Peter Agn (Son) Department of Health Important: If item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Reformed Cemetery Method of Dis position Date 20c. Location - City or Town, State 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 1X Burjal 4/29/2012 Middletown, MD 4 Donation Si Auture of 2007mand Address Thrompson Funeral Home POB 18, Middletown, MD 21769 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between cause (Final Onset and Death Physician. End stay disease or condition 1 week Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform after death.

Director: After this certificate Yes 2 X No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No filled in by the Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D38833 APAIL, 30,2012

State Registrar 31. Date filed (Mo.

30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

gistrar's Signature

ARRAGE.

TEWOAILS Rd

6355

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 06 Aldridge 2012 ores MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND Medical Baltimore Baltimore 1 Year If Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 28, 1954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗌 M 2 🕱 F Months 218-58-1110 Maryland 57 Director Auq. Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Dorchester 1 X Yes 2 No Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21613 701 Race Street Apt. 205 should be filed wilthin 72 hours after death v and Mental Hygiene. 'is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Processing Line Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Newcomb Melvin Ellsworth Aldridge, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Health an Important: If item 27 is any injury or other trau Steven W. Aldridge/Son PO Box 1022, Hurlock, MD 21643 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of recemetery, crematory or other place)
Petersburg Cemetery 05/12/12 1 X Burial 2 Cremation 3 Removal from State Hurlock, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Framptom Funeral Home Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Septicemi Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Intravasculor 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Secondary to Hepatitis Band C 24a. Was an cirrhosis autopsy Hepatarena within 24 hours after death.

To the Funeral Director: After this certificate Sun drome 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 MInpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 \(\subseteq \text{Yes} 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 18718922 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Britiney Williams South 51. Greene 31. Date filed (Month, Da 32 Registrar's Signature State and o Registrar

DHMH 17 Rev 7/2009

AS 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 4, 2012 8:00 Ralph Edwin Barnes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 150 Llewelyn Lane Calvert Huntingtown Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth 1 X M 2 🗆 F 0171271956 220-66-6927 56 Director Yrs. MD Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Huntingtown 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 150 Llewelyn Lane 20639 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Heavy Equipment Foreman Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Barnes Clara Perry and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Barnes / Wife 150 Llewelyn Lane, Huntingtown, MD 20639 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Southern Memorial Gardens | 05/08/2012 Dunkirk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Getf 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ End Stage Metastatic Cancer Colon disease or condition Medical resulting in death) Examiner Coronary Artery Disease Sequentially list conditions, Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Examir Cause (Disease or linjury that initiated events that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death Yes 2 No ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown has been signed to the period of the period 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform Hospital or Attending Physician: The certificate 2 🗌 No Yes 2 X No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဂ 1 🗌 Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 X Natural 5 Pending 2 Accident М 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20639 n MD 30. Name and address of person who completed cause of deat (Item 23a) (Type, Print) Island Rd

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ma Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death esapeak prida orcheste 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕡 F (Month, Day Months Min Director Maryland 0 Usual Residence of Decedent or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Ves 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 21613 5 Avenue 11. Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 þ 1 Yes 2 No If Yes, Give Year or Dates 3 ☐ Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Seafood Industry and Mental Hygien is marked other th Worker Be be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Meekins permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Mary eekin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address / Facility MD.2161 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician COPD disease or condition resulting in death) Medical Due to (or as a consequence of): Examine PULMONALE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No ☐ Pregnant ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ≥ 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျ 1 🗌 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural Accide 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Ocertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 7 D69234 04 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 CAMBRIDGE JEEVAN ERRABOLU 503 BYRN STREET MD egistrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Olive Tyler Bramble 0500 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Cambridge Dorchester General 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral t. 30,1925 Min 1 M 2 X F 220-12-1101 Sept. **Director** 86 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 115 Wisteria Drive 21613 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married b ☐ Yes 2x No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: white Specify "natural", 3 Nidowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Services supervisor other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ Oliver Tyler Page 1 and 2 should be from to Health and Ments Lillian Roberta Wroten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 103 Wisteria Drive, Cambridge, MD Paul O. Tyler nephew Department of Health Important: If item 2: any injury or other t other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ${\bf X}$ Burial 2 \square Cremation 3 \square Removal from State 5/7/12 Dorchester Mem. Park Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fu/monory Onset and Death Immediate Cause (Final Physician/ Acute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeets). Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗆 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? this certificate 1 Yes Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 Ho Other: 1 Yes Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMPRIDGE MD 216/3 503 BYRN

State Registrar 31. Date filed (Month, Day

Sample

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $20^{\rm Year}$ 4:00 P M May Melvin Burris, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Caroline 27179 Temple Road Marydel 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth . Age (In vrs. last birthday **Funeral** nth, Day, ^{Year)} 19<u>68</u> 1 X M 2 - F Hours Min. Sept 43 Director 212-86-9712 Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at death with the Maryland Director 1 ☐ Yes 2 💢 No Maryde1 Maryland Caroline 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 21649 27179 Temple Road ral", or items a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married ☐ Yes Yes, Give Page 1 and 2 should be filed within 72 hours after 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: 3 Widowed 4 X Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) new construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Christine Ware Harry Melvin Burris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27179 Temple Road; Marydel, Maryland Christine Burris / mother other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory | May 11, 2012 Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) Fulleral Service Licenses 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ COLE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be very hours after death.
Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending iniury work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical 29a, Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifie 29d. Date signed (Month. Dav. Year) 8 D0066400 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qiwei Gai, MD Teal Drive: Su 3021 Easton, MD 21601 9°2012 State

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Helen A. Black-Hubbard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FENINSULA Medical KegIONAL 546156414 Year If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Hours **Director** 222-22-9245 1 □ M 2 🛣 F 73 or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director Dorchester Hurlock 10e. Street and Number 10f. Zip Code Completed by Funeral 5005 Lucy Fish Lane 21643 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?
1 ☐ Yes 2 ☑ No Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🔲 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Retail Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred (Johnson) Herbert A. McIntire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau 5005 Lucy Fish Lane Hurlock, MD Harry Hubbard Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hollywood Cemetery Signature of Euneral Service Licenses 22. Name and Address of Facility nu Melvin FH 15522 S. DuPont Hwy., Harrington, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shoch Septic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** irrhosii 0.1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by Renal Mailure Records, perform Yes 2 Division of Vital 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: 2 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of Certificate: (Month, Day, Year) 5 Pending Natural 124 hours after death.

Funeral Director: A letely filled in by the fi 1 \sum Yes Accident Investigation Suicide Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 To the P 29b. Signature and title of certifier ho L 10070129

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IRFAN MUINUDDIN, MD

MAY 08

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

9. Birthplace (State or Foreign 12/12/1938 Pennsylvania 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Manufacturing 21643 20c. Location - City or Town, State May 3, 2012 Harrington, DE 19952 Interval Between Onset and Death 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 4-28-2012 SALISBURY MD

3. Time of Death

1721

4c. County of Death

HICOMICO

Registrar DHMH 17 Rev 06-201

State

CARROLL

STREET

100 GAST

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Phyllis Imogene Bender Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Allegany WMHS Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min. Hours 175-24-2129 **Director** 1 🗆 M 2 🕱 F 82 1930 Pennsylvania March 20, Usual Residence of Decede 28a-f show 10c. City, Town or Location notified at 10a. State Director Grantsville 1 X Yes 2 No Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21536 USA 187 Grant St. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public School <u>Assistant Librarian</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o Department of Health and Menta Ingortant: If item 27 is marked any injury or other traumatio 2 Albert R. Wagner Erma A. Bockes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15042 Main St., Wellersburg, PA Thomas L. Bender/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery | May 12, 201|2 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Lice P.O. Box 275, Grantsville, MD 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause Final Approximate Interval Between Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALS 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month 5 Other (specify) Pregnant at time of death ☐ Pregnam
☐ Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records. Be Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an sate has l autopsy perform 1 Yes 2 1 Yes 2 No 25. Was case referred to me 26. Place of Death (Check only one) or Attending Physician: funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital _2 No Certificate: To 1 Yes 1 Dinpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Beath 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After injury Natural 5 Pending work! 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within To the Signati and title of ce

Registrar

DHMH 17 Rev 06-2011

State

21502

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 1 2012

James Raver, 12500 Willowbrook Rd., Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 0105 Song K. Cho 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Republic If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Director 004-82-3831 1 **X** M 2 \square F 58 April 11, 1954 of Korea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Germantown 1 Yes 2 X No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Monarch Vista Court 20874 Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Asian Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Geun Hang Cho Son Jung Suk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18963 Ferry Landing Circle, Germantown, MD 20874 Victoria Cho - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Souls Catholic Cem 05/01/2012 Germantown, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. |11800 New Hampshire Ave.,Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Respira Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying attending physician and for use as the burial transit Exami Cause (Disease or injury that initiated events meta Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Day ned by the at detached f Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 2 No 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No injury 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Ctr. 9901 Donic John mD 2. Registrar's Sigr 03 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cho Во Chan April 2 Day 201^{xea} 4:20 а м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 098-52-5641 Director 86 1 M 2 XF May 29, 1925 China permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exymination matter traumatic event, the Medical Exymination results to notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Takoma Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 USA 7051 Carroll Avenue, Apt. 207 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: Asian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7051 Carroll Ave., Apt. 207, Takoma Park, MD 20912 Kong Tung Chan/Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cem April 30, 2012 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi 22. Name and Address of Facility Francis J. Collins Funeral Home 500 University Blvd., West, Silver Spring MD 2090 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multi-Organ Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Severe Malnutrition Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir sician and burlal-transit To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and To the Funeral Director After this certificate has been signed by the ettending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burial gransit Advanced Age Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Urinary Tract Infection Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 5 Other (specify) Month 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 ☒ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) April 30, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lylla Shahab, MD 7600 Carroll Avenue, Takoma Park, MD 20912 31. Date filed (Month, Day, Year) State NAY 03 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year May 1:15 Physician/ 7 Mary Jeannette Churchey Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Williamsport Retirement Village Williamsport If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) 110 • 14,1925 1 🗆 M 2 💢 Maryland 217-32-7130 86 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. Director 1 X Yes 2 No Hagerstown Maryland Washington County 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 420 Jefferson St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Personal Residence Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel L. Rudisill George W. Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 420 Jefferson St. Hagerstown, MD 21740 Kitty L. Shoop-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 5-8-2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARCTION Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any leading to immedicause. Enter Underlying Due to or as a consequence of or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MITRAL VALVE INCOPAPETENCE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ATRIAL FIBRILLATION autopsy perform has Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 27 Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident 2 Accident
3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 33700 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAMSPORT. N. ARTIZAN

Registrar
DHMH 17 Rev 7/2009

State

0 9 2012

Brendon	Edward	Colliflower
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		1- For State Registrar			Ce	ertificat	e of L	Death			Re	eg. No.		
Physicia		Decedent's Name (First, Midd									Date of Dea Month		ear	3. Time of Death
Medical Examir	ner	Brendon Edward									May 6, 20	12	100	0002 hrs
		4a. Facility Name (if not instituti 17734 Rench Road	on, give stre	eet and nun	nber)			. City, Town, o Hagerstow		of Death		4c. County Washir		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birtho	lay)	If Under 1 Ye	_	ler 24Hrs.	8. Date of Bir	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign		
Director		216-43-1570	1 ∑∑ M	2 F		17	Yrs. Months Days Hours Min. Nov.7, 1994 Foreign Country)Mar							untry)Maryland
a	Ì	Usual Residence of Decedent			Lia ei	-								
W any		10a. State 10b. County				, Town or								10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	ģ		ngtor	1	I:	lager								
Mary r 28s	Director	10e. Street and Number						10f. Zip Code			11	0g. Citizen of W		ntry?
th the 23s o	의	1028 Brinker I			ot.102		بليب		740			US		
ath wi	Funeral	11. Marital Status 1 X Never Married 2 N		Armed For		J.S. 1		Decedent of H , specify Cuba			ecify Yes or No Rican, etc.)		e - Ameri ite, etc.	can Indian, Black,
ter de		3 Widowed 4 Di	1 orced If Ye	Yes s. Give Year	2 X No		1 V	es 2 X N	o specify	,		Specify	Whit	ie .
5-0036 ed within 72 hours after death with the lygiene. other than "natural", or items 23s or the Medical Examiner must be notifie	ā	15. Decedent's Education (Spe	or D	atac.	e completed)		cedent's	Usual Occup	ation (Give	kind of w		16b. Kind of B		
72 ho	ete	Elementary/Secondary (0-12)		College (1-	4 or 5+)	du	ring mosi	of working lif	e, DO NOT	use retire	∋d)			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	Completed	12					Stu	dent				Ed	ucat	ion
1 other	ပို	17. Father's Name (First, Middle	•									Maiden Surnam	9)	
d be f fental	8	Chad Edward Co				1400					zabeth :			
D 2 shoul and M 7 is m	의	19a. Informant's Name/Relations Chad E. Collin			ther							ber, City or To		, Zip Code) , MD 21740
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygione. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a. Method of Disposition	. 10 11 01					n (Name of c		1 7	Date	20c. Location		
Baltimore, permit. Pages I an Department of Hee Important: If itel		1 Burial 2 Cremation	_	erooval fro	m State	crematory		place) Iem. Pa	rk	05_1	2_2012	Willia	mana	rt,Maryland
it. Partmen	d	4 Denation 5 Other S			JGL	CELITO							-	-
Ba Depa Injury	21. Schatur of Fun al Se dice see 22. Name and Address of Facility Osborne Funeral Hor 425 S. Conococheague St. Williams;										ome, spor	P.A. t,MD 21795		
Physician	1	23. Parl I. Enter he disease, of			used the death	n. Do not e								Approximate Interval
/Medical	/Medical failure, List only one cause on each line.											Between Onset and Death		
Examiner	-1	or condition resulting in death)			consequence	of):								
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	흹	if any, leading to immediate cause. Enter Underlying Cause	Due t	o (or as a o	consequence	of):								
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O, be en sician sician	/Medical	UNPENDED	100	ENDED										lu.
8760, ificate be ig physici		IF FEMALE: 23b, Was decedent pregnant in t		c. If yes, ou Live bir	utcome of preg th	gnancy 2	☐ Fetal	death 3	Ectopi	c pregnañ	icv	23d. Date o Month		lay Year
Box 68's death certifing the attending of for use as	ᇋ	past 12 months?	4	=-	nt at time of d		=	(Specify)		o p. og	,			,
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that the ned by detach	by Physiciar	Part II. Other significant condi	ions cont	ributing to	death but not i	resulting ir	the und	erlying cause	given in Pa	art I.				the cause of death?
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ords, w requir	E E										24a. Was a autop	sy	prior to co	topsy findings available ompletion of cause of
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certifi ector,	25. Was case referred to medical 26.Place of Death (Check only one)													
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ding Ph		27. Manner of Death 1 Natural 5 Pen		8a. Date o Month, 1 May 6, 20		28b. Tim 0002 h	ne of Inju rs	· 1 ·	uryat Wor⊩ Yes 2 🗹	. ir		low injury occur ixed object		n
Sior Attend death death sector:	cat;	J Fell	stigation _								201 1 1 10			IB (N)
Division of Vital Records, P.O. sopial or Attending Physician: The law requires that th hours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach?	Certification:	dete	a not be		of Injury - At h			actory, office	building, e			treet and Numb tate) Road, Hagers		ral Route Number, City
Lospit 1 hour uners		29a. Certifier	- 1		Major Roa			l at the time.	data and ni			e(s) and manne		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) 2 Medical Exa	miner:On t	he basis of	examination a									
\$ \$ \$ 8	Š	29b. Signature and title of certific		manner sta	itea.			29c. Licen	se number			29d. Date sign	ned (Mor	oth, Day, Year)
	- [D-~)L.						0.0	M.E.			May 6, 20	12	
41	ŀ	30. Name and address of person	who compl	eted cause	of death (Iten	n 23a)		_1						
W-5		Donna M. Vincenti, M	D Ass	istant Me	edical Exa	miner	900 W	. Baltimore	e St ree t,	Baltim	ore, MD 212	223		
Sta	100	31. Date filed (Mon Aa), Y(V)	2012	32. R g	istrar's Signat	ure		w						
Registr	r: 1 d			No. of Concession,	of square, or other trans	Service of	A STATE OF THE PERSON NAMED IN							

			Please	Type or Print in				-	-	Jible.	
			For State	State of Maryla		ent of He ate of De		Mental Hy	giene 2	012 15	921
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Certino	ale of De	Jaur	2. Date of De	Reg. No.	3. Time of De	eath
	Physicia		Richard	Horold	600	Per.	Jr	Month	Day	Year 2 4:40	
of the A	Medic Examin	er	4a. Facility Name (if not institution, give				ocation of Death		4c. County	y of Death	
-			University of r				3 MIH N				
	Funeral Director		5. Social Security Number 6. Security Number 1	\mathbb{X} M 2 \square F 7. Age (In yrs.	Yrs.		Hours Min.	8. Date of Bird (Month, Da	y, Year)	9. Birthplace (State or Fo Country) Maryland	oreign
-			Usual Residence of Decedent	01			1	Oct. 26	3,1950		
	ryland -fsho ied at	Director	10a. State 10b. County		ity, Town or Location gerstown					10d. Inside City L	
	ne Ma or 28a notif		Maryland Washingto	on Country Hay		Zip Code			10g. Citizen of		
	with t	Funeral	238 North Coloni	al Dr.		21742	2		U.S.A		
	death items ner m	Fun	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was De	cedent of Hisp pecify Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian,	
336	s after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1 ☐ Ye	s 2 🔀 No	Specify:		Specify	White	
21215-0036	hours natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Decedent's U	Jsual Occupati	ion ring most of work	dina	16b. Kind of E	Business/Industry	
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d 2	led wir Hygie other ent, tl	Be	12 17. Father's Name (First, Middle, Last)		Platfice		18. Mother's Nam				
/lan	d be fi Vental arked atic ev	욘	Richard Harold C	Cooper, Sr.			Vernabe	lle Row	land		
Maryland	permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty		19b. Mailing Add						
e,	and 2 Health tem 2;	-	Dorothy A. Cooper		Place of Disposition (Date		MD 21742 - City or Town, State	
Baltimore,	age 1 ent of nt: If ii y or c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crematory dar Lawn M	or other place)	i	-2012		stown, MD	
alti	permit. F Departm Importa any injur	ı	21. Signature of Funeral Service Licens		22. Name	and Address	of Facility Dou	ıglas A.	Fiery	Funeral Home	
<u>B</u>	8 9 E 8 8	4) lungla A	Fren						own, MD 2174	+2
	ALTER CO.		23a. Part 1. Enter the disease, or comp shock, or beart failure. List only of Immediate Cause (Final	blications that caused the dea ne cause on each line.	th. Do not enter the n	node of dying,	such as cardiac	or respiratory ar	rest,	Approximate Interval Betwee Opset and Dea	en ath
8	Medical		disease or condition resulting in death)	a. Due to (or as a consec		Goli	s M			Opset and Dea	, 5
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	sit a	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to lor as a cons		T	forch	-		30 do	
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ox 6	ath ce attend for us	cian,	in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live Birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3 🔲 Ector					ate of delivery onth Day Yea	ar .
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oce	hysician: The law r nis certificate has b il director, page 2 s	ğ						24a. Was auto perfo	psy prmed?	Were autopsy findings ava prior to completion of caus death?	se of
Œ.	ificate or, pa	Be Co	25. Was case referred to medical			26. Plac	e of Death (Chec		2- No	1 Yes 2 No	-
Vita	Physicia this cer al direc	P B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient _3 ☐	DOA Other:	4 Nursing H	ome 5 🗆 Resi	dence 6 🗆 Oth	ner (Specify)	
οl	ing Pr	ate:	27. Manner of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?		28d. Describe l	now injury occur	red	
Division of Vital Records,	Attend death ctor: / cy the	ıţį.	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h	M nome, farm, street, fac		es 2 🗆 No	28f. Location (Street and Numb	per or Rural Route Number,	
Divi	tal or / rs after al Dire ed in t	S	4 Homiciae determined	building, etc. (Speci	fy)			City or Tov	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical Certificate:	(Check 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati	on and/or investigation	, in my opinion,	, death occurred a	at the time, date a	and place, and du	ue to the cause(s) and manne	er stated.
	To the within 2 To the Comple	Š	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the best of	my knowledge, death	occurred at the 29c. License r		lace, and due to		manner as stated. ed (Month, Day, Year)	
	->-0		du Hoe	can CRNP		R07	9848		may	2, 2013	2
44	17			completed cause of death (Ite	m 23a) (Type, Print)			2		2 2 / 2	1
الع] =		John Haga V	32. segistrar's Sign	m 23a) (Type, Print)	ne st	reat 6	souther	000	11 2/20	I
	Stat Registra		MAJ II. S	Service Shar	A. A	Share and the same of the same					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death CCHD ajs 5/7/12 ? Registrar Amended #5
Decedent's Name (First, Middle, Last) #5 per ff 2. Date of Death April Physician/ Anna Roth Cole 17 Day 20Î2 1:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Maryde1 Oueen Ann'e 3216 Peters Corner Road 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Social Security Numb 222-10-951 **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours (Month, 1 🗆 M 2 🗶 F 93 Director Nov. 18, 1919 Usual Residence of Deceden 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 💆 No MD Queen Anne's Marvde1 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21649 3216 Peters Corner Road ral", or items a 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates f Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farm Wife Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ္ဂ Julia Bruncz Stephen Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marydel, Maryland; 3316 Peters Corner RD; 21649 Daniel Stephen Cole/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H
Important: If ite
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Templeville Cemetery April 23,2012 Templeville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 160 Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending properties for use as use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Tunknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 2 🗌 No Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 2 Natural injury work? 5 Pending 24 hours after death. Funeral Director: A Accident Suicide 2 🗌 No Investigation 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within Z Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

W3

DHMH 17 Rev 7/2009

State Registrar JEFFRET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

UKENY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Starkey		en, Jr. St I-For State Registrar	ate o	of Maryla		epartment o Certificate o		l Mental	Hygi		. No.	201	2 1592
Physicia Medical Examir	n/	Decedent's Name (First, Midd George Starke			Ι×					Date of Death Month April 23, 20		Year	3. Time of Death 1730 hrs
Medical Examin		4a. Facility Name (if not institution				-	4b. City, Town, or L	ocation of D	eath	April 23, 20	4c. Coun	ity of Death	
1		3524 Green Point Ro					East New Ma				Dorch		W
Funeral Director		5. Social Security Number 220-46-7687	6. Sex	M 2 F		yrs. last birthday)	Months Days	tf Under 24 Hours	Min	09/10/	-	Foreig	thplace (State or gn Washington luntry) DC
any	F	Usual Residence of Decedent 10a. State 10b. County			10c.	City, Town or Loca	tion						10d. Inside City Limits
	ō	Maryland Dorc	nest	cer	I	East New	Market						1 Yes 2 X No
Maryl.	Director	10e. Street and Number 3618 Green Poi	4= 3	D = a d	_		10f. Zip Code 216	. 2 1		100	g. Citizen of	What Cou	ntry?
with the		11. Marital Status		12. Was Dec			as Decedent of Hisp	anic Origin?				ace - Amer	ican Indian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene. tant: If item 27 is marked other than "natural", or items 23s or 25s-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 X Never Married 2 N		Armed Fo	2 X		es, specify Cuban,		ierto Ric	an, etc.)		hite, etc.	hite
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6 n 72 hor an "na ical Ex	Completed	Elementary/Secondary (0-12)		College (1	-4 or 5+)		nost of working life.	DO NOT use	e retired)		A., +	omobi	10
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MD 21215-0036 12 should be filed within 7 th and Mental Hygene. 127 is marked other than umatic event, the <u>Medical</u>	2	19a. Informant's Name/Relations Joanne C. Carr			er		g Address (Street Overlea						e, Zip Code)
re, N I and 2 Health Fitem 2	ŀ	20a. Method of Disposition				20b. Place of Dispo crematory or o	sition (Name of cem						Town, State
Baltimore, sermit. Pages I an Department of Hee Important. If itelinjury or other tr		4 Donation 5 Other S	oecify:			Crematory (Of Delmarva						lawa <u>re</u>
Baltimore, MD permit. Pages I and 2 sho Department of Heath and Important: If item 27 is injury or other traumati		21. Signatural uneral Service	Licers	9	lle	Z Ze 10	Name and Address 11er Fune 6 Main St	of Facility eral H creet,	ome, Eas	P. O.	Box Marke	207 t, MD	21631
Physician /Medical	4	23a. Part I. Enter the disease, or vailure. List only one cause	compli	cations that ca	aused the o	death. Do not enter	the mode of dying,	such as card	iac or re	spiratory arres	st, shock, or	heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)		Atheroscler Oue to (or as a		diovascular Dis	sease						Death
When		Sequentially list conditions,	b										
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C.	oue to (or as a									
uted d ansit	Exa	events resulting in death) Last	d.	oue to (or as a	conseque	nce of):							
D, be executed sician and purial - transit	dical	UNPENDED		AMENDED									
68760 certificate b nding physise as the bu		IF FEMALE: 23b. Was decedent pregnant in t	he	23c. If yes, o			etal death 3	Ectopic pr	egnancy	,	23d. Date Month	e of deliver	y Day Y ear
Box 6876: death certificate the attending phy	Physician/M	past 12 months?	known	4 Pregna	ant at time	of	ther (Specify)						
D. B. t the de by the		Part II. Other significant condi		9 Unkno		not resulting in the	underlying cause gi	iven in Part I		23e. Did tob	acco use co	ontribute to	the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ras after cleath. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	d by									1 Yes		3 Pro	bably 4 Unknown
ords aw requ	Completed									24a. Was ar autops perforn	y		utopsy findings available completion of cause of
Rec: The lificate lificate l		25. Was case referred to medical	1 1		-		26 Place	of Death (Ch	ook only	1 Yes 2			es 2 No
Vital ysician his cert directo	ğ	examiner?	1.0	ospital: 1 1	npatient	2 ER/Outpatien		Othor: -			tesidence	6 🗸 Othe	er: Scene
ling Ph	H	27. Manner of Death		28a. Date (Month,	of Injury Day,Year)	28b. Time of		y at Work?		d. Describe ho	ow injury occ	curred	
Sion Attend r death. rector: by the f	catic	2 Accident Inve	stigatio	28e Place	e of Injury -	- At home, farm, stre		es 2 No		f. Location (St	reet and Nu	mber or R	ural Route Number, City
Divis	je i		ld not b rmined	e						or Town, Sta		•	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical Certification:	Concon only	miner:		of examinat	owledge, death occu tion and/or investiga							
F 3 F 8	Me	29b. Signature and title of certifi		0	1 /	/	29c. License O.C.N				29d. Date s		onth, Day, Year)
		30. Name and address of person		•		,						-	
3	212	Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year)			al Exam	iner 900 W.	Baltimore Stree	et, Baltime	ore, M	D 21223		-	
St Regist	. 1.5-	HAY 0.3			estile so	B. po	M						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May Physician/ 5:50 pm 01 Jeanette M. Dunn 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Senior Living Ellicott City Howard 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 579-01-9082 **Director** 1 🗆 M 2 🗶 F 93 02/27/1919 Washington, DC Usual Residence of Decedent or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Columbia 1 Yes 2 X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 6618 Belleview Drive 21046 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed Specify 3 ¥ Widowed 4 □ Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Cafeteria Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edward Hoover Betsy Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert E. Dunn - Son 6618 Belleview Drive. Columbia. Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory 05/09/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee alnua 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the buriate Physician/Medical IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Other: 1 Yes ပ္ 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) LVINA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending X Natural Accident Investigation 2 Accident
3 Suicide
4 Homicide filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 P.O. Records, Hospital or Attending Physician: The law requires Division of Vital To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completely

DHMH 17 Rev 06-2011

Registrar

State

29b. Signature and title of certifier

Andrew Lazris,

MAY 03 2012

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

3 🗆 Certifying Notes Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D47447

6334 Cedar Lane, #103, Columbia, Maryland 21044

May 02. 2012

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Betty Ann DeWitt Betty Ann De		State Registrar				Cei	rtificate	of Death			Reg. No.	201	2 150
A Sale When of the electron endoughous server and numbers of the City, Tourn or Location of Damity Amount Mannor Health Care Center Social Security Numbers Sec	ian/	Decedent's Name	e (First, Middle,		4 D.	XX/:44				Month		Year	3. Time of Death
Moran Manor Health Care Center Subscission Shall plants Subscission Subscission		4a. Facility Name (if	not institution.			evvitt	4h City	Town or Location	of Death	05			
South South Number S. Par. 7.2 Vis. 7.2 Vis. 1.0 Date of Burth 1.0 Dat	illei	· ·			,		is. Oity,				40.000		
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Secretarian	rai						10f. Zip			ļ	10g. Citizen		•
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White 15. Recedent's Education (Speedorf) with prime dynamic completed in Speedorf) 16. Decedent's Usual Occupation (Speedorf) with prime dynamic completed in Speedorf) 17. Father's Name First, Middle, Last) 18. Malaries Name First, Middle, Last) 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequentially Recorded in Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Malling Address, Street and Number or Plural Route Number, City or Town, State 19. Sequential or Speedorf 19. Sequential or Speedorf 20. Name and Address of Sacilly 21. Signature or Speedorf 22. Signature or Speedorf 23. Part 1. Effort the desiase, or complexations that caused the death. Do not enter the recision of cyling, such as cardiac or respiratory arrest. 19. Due to (or as a consequence of): 21. Due to (or as a consequence of): 22. What accelerate registrate or speedorf 23. Due to (or as a consequence of): 24. Due to (or as a consequence of): 25. Place of Death, Check only one) 26. Was accelerate registrate or speedorf 27. Malling Address of Town, State 28. Sequentially list conditions 28. Due to (or as a consequence of): 29. Due to (or as a consequence			ried 2 🗆 Marri	ed 1 🗌 Yes	2 🗷 No		_	_		Rican, etc.)		Black, White	
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarie) 18. Mary H. Sebold 18. Mary H	nple		cify only highes	t grade completed)		(Give	kind of worl	k done during mo	st of work	ing	16b. Kind o	of Business	Industry
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S. Wade Houser / Son Son Main Street, Deer Park, MD 21550 20c. Location - City or Town, State 1 but 2 Commands Removal from State 4 Danation 5 Other (Specify) 21. Signature of Fungued Service Liceases 22. Name and Address of Facility 22. Name and Address of Facility 23. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final claused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final claused the past 12 months) 23c. If yes, outcome of pregnant in the past 12 months 23c. If yes, outcome of pregnant in the past 12 months 23c. If yes, outcome of pregnant in the past 12 months 23c. If yes, outcome of pregnant in the past 12 months 23c. If yes, outcome of pregnant in the past 12 months 23c. If yes, outcome of pregnancy 1 Live Birth 2 Felal death 3 Estopic pregnancy 1 Yes 2 No 3 Probably 3 Month Day Year 1 Yes 2 No 3 Probably 3 Month Day Year 1 Yes 2 No 3 Probably 3 Month Day Year 1 Yes 2 No 3 Probably 3 Month 2 Month	۴				DeBerry					Ma	ry H. Sel	oold	
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21. Signature of Furgeral Service Licenses 22. Name and Address of Facility Burriack-Fredlack Funeral Home. P. A. 21 North Second Street. Oakland. MD 215t- 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreal. Approximate and sease or conditions of the sease on each ins. Immediate Cause (Final classes) and other institutions of the sease of cache institution of the sease or conditions of the sease or condition					State	cemetery, crei	matory or ot	her place)				-	
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FFEMALE: 236. Was decedent pregnant 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year	1	shock, or hea Immediate Cause (disease or condition	rt failure. List or (Final	nly one cause on ea	ch line.	al co							Interval Between
24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings availated prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA 28a. Date of injury 28b. Time of injury 28b. Time of injury 28c. Injury at work? 3 Suicide 4 Homicide 28a. Describe how injury occurred 28a. Place of Injury - At home, farm, street, factory, office 28b. Place of Death (Check only one) 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how in	er	Sequentially list co	nditions,	b. Due to	or as a consec	ulence of							
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	State of Marylar	nd / Department of Health and Mer	ntal Hygiene
	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 20 2 5925
Physician/ Medical	Flora Ann Fisher		Date of Death Month 22, Day 2012 Year 5:50p M
Examiner	Suburban Hospital	4b. City, Town, or Location of Death Bethesda	4c. County of Death Montgomery
Funeral Director	5. Social Security Number 579-28-3152 Usual Residence of Decedent 6. Sex 1	87 _{/rs.} Months Days Hours Min.	Date of Birth Month, Day, Year) Peb 25, 1925 9. Birthplace (State or Foreign Country) North Carolina
ne Maryland rr 28a-f show notified at	10a. State DC 10b. County N/A	ity, Town or Location Washington	10d. Inside City Limits 1 Yes 2 □ No
Jeath with the Marylanc litems 23a or 28a-f she ler must be notified at Euneral Director	10e. Street and Number 2702 Wisconsin Avenue, NW	apt#703 10f, Zip Code 20007	10g. Citizen of What Country? United States
036 s after crall, or Examin	1 Never Married 2 Married 1 Yes 2 No	.S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar 1 Yes 2 M No Specify:	Specify: Black
tore, Maryland 21215-003 ge 1 and 2 should be filed within 72 hours at it of Health and Mental Hygiene. If it flem 27 is marked other than "hatural" or other traumatic event, the Medical Exa		(Give kind of work done during most of working life. DO NOT use retired) Telephone Operator	16b. Kind of Business/Industry AT&T
yland 's d be filed v Mental Hyg arked othe attic event,	17. Father's Name (First, Middle, Last) Thomas Davis		st, Middle, Maiden Surname) Graha m
e, Mar and 2 shoul Health and em 27 is m ther trauma	19a. Informant's Name/Relationship (Type, Print) Allan S. Davis / son		te Number, City or Town, State, Zip Code, 89102 enue, apt#270, Las Vegas, NV
ant and	20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗆 Donation 5 🗆 Cther (Specify)	Place of Disposition (Name of 5/2/20).	12 20c. Location - City or Town, State Brentwood, Maryland
Balti permit. Depart Import any inji	21. Signature of Funeral Service Licepsee	22. Name and Address of Facility McGur 7400 Georgia Avenue,	ire Funeral Service, Inc. NW, Washington DC 20012
Physician Medical	resulting in death) a.	Lung Cancer Stage IV	piratory arrest, Approximate Interval Between Cnset and Death
Examiner	Due to (or as a conseq		
defection and the burishing the burishing the burishing the burish transit the burish transit call Examiner	if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseq C. Due to (or as a con		
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Box death ne atte ed for	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
(<u>G</u> # E		sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1XXYes 2 \(\text{No} \) 3 \(\text{Probably} \) 4 \(\text{Unknown} \)
7 8 8 2			24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
F 10 V & Prystal Be Physician: The tris certificate it rail director, page: To Be Cor:	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No Hospital:	26. Place of Death (Check only	one)
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440 5 3 4 8 P	▶ 11. Shyanduran	29c. License number D53367	29d. Date signed (Month, Day, Year) April 23, 2012
00) bu	21 Date filed (Month Day Year)	Georgia Avenue, Suite #117,	Silver Spring, M D 20902
State Registrar	MAY 03 2012	parl.	

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Physicia Medic				sher, Sr	•					Month 5	Da 2	2012		1:45 A ^M
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2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at		19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mai	ling Addre	ss (Street	and Number or Ru			Town, State, 2	ip Coa	/e)
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1	Certifying Phy	sician: To the best of	my knowle	edge, death	occured a	at the time	, date and place, a	nd due to the c	ause(s) ar	nd manner as s	tated.	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 May 8, 20 am Physician/ Robert Wilson FIDDLER, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington 341 Ridge Avenue Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 19 1935 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F West Virginia Director 214-34-0532 Yrs May 76 Usual Residence of Decedent 28a-f show 10a. State 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Washington Hagerstown Maryland 0 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 21740 USA 341 Ridge Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural". Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. City Government 6 Surveyor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked မ Lonnie Fulkner Fiddler Mammie Viola Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ridge Avenue, Hagerstown, Maryland 21740 Anna Fiddler - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 5/10/2012 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home ⊀415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweel shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ CONVINONO Medical resulting in death) Due to (or as a confiquence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 1 Tyes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 📈 No Other: မ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 2 Accident 3 Suicide work? 5 Pending 2 🗌 No Investigation Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Records,

State Registrar Signature and title of certifier

31. Date filed (Mor

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month, Day, Year)

Street Heigensterne MD2740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g927 5-18-12 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sue Ellen Foltz Day Month Physician/ ρ_{M} 10:10 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 215-98-4328 Director 1 M 2 X F 45 June 29,1966 Maryland Usual Residence of Decede or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 X No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Page 1 and 2 should be filed within 72 hours after death with 9617 Crystal Falls Drive 21740 U.S.A.12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ "natural", or 1 Never Married 2 Narried 1 ☐ Yes 2 🛣 No If Yes, Give 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify. White Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene 12 Homemaker Home marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I မ Donald L. Pryor Jo Ellen Emery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 John A. Foltz, Sr. (Husband) 9617 Crystal Falls Dr. Hagerstown, Maryland 21740 Important: If item 2 any injury or other once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1 Burial 2 💢 Cremation 3 🗆 Removal from State May Smithsburg, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home -2 AULS 12525 Bradbury Ave. Smithsburg, Maryland 21783 🔞 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical SOL Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ igned by the atte in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No 1 Yes Yes To the Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Hospital patient 2 ER/Outpatient 3 DOA Other: 1 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate; 28d. Describe how injury occurred 1 Natural 5 Pending injury work? s after death. I Director: Aft 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Funer completely fi 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 7 only one 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole Perrotte 4111 Hagerstown, Md. 21742 Medical Campus Dr. Ste. 1153 201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ PAULA RUARK BEATH GIBB Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** DORCHE GENERAL HOSPITA If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, 12-01 1 🗆 M 2 🕱 F Days Country) Hours **Director** 218-58-1097 -1950Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location with the Maryland 10a, State 10d. Inside City Limits Examiner must be notified at Director 1 Tyes 2 No MD DORCHESTER CAMBRIDGE 10g. Citizen of What Country? 9 10e, Street and Number 10f. Zip Code 23a Funeral 2216 HORN'S POINT 21613 ROAD USA 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married ģ Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Bonce. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) EDUCATION 5+EDUCATOR Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ELLEN PARKS PAUL RUARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 HORN'S POINT RD. CAMBRIDGE, MD. 21613 JIM GIBB/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DORCHESTER MEM PK 5-7-2012 CAMBRIDGE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High St cambridge.Md.21613 Newcomb and Collins F.H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 10005U Medical Due to (or as a insequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should ! 24a. Was an 24b. Were autopsy findings available page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 KER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after death in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours at To the Funeral D completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cortifying Marse Practionary the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death May 11 Physician/ Day 2012 5:15PM ^M Mary Ellen Hoffman Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 14115 Craddock Road SW Cresaptown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 QF Min Jul 18 Director 216-22-6689 92 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location with the Maryland **Funeral Director** 10d. Inside City Limits be notified Cresaptown MD Allegany 1 X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a (21502 USA 14115 Craddock Road SW items ? permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖁 No Specify. Completed 3 XWidowed 4 Divorced white Year or Dates th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Finan Center Nurses Aide Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ပ Cerina Wilfong Jacob Hottle 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 16800 Old Loartown Rd. SW Frostburg MD 21532 Barbara Tomlinson Department of Health a Important: If item 27 is any injury or other tra once. daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State MD State Veteran's Cemetery 5/15/2013 Flintstone MD ☐ Donation 5 ☐ Other (Specify) of Funeral Sen 22. Name ars carpellif Furileral Home, PA ignatur 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, of complications that caused shock, or heart failure. List only one cause on each line nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ollonon) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter charactering Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE nse Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performed? Yes 2 1 Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes the 1 Investigation ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi

State

Registrar

Broadwa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lesus Ian M.D.

Date filed (Month, Day, Year)

MAY 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 344 Roxy Delores Horning PM 2012 MAY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 217-28-5290 Director 1 🗓 M 2 🗆 F 79 Oct. 28,1932 Maryland Usual Residence of Decedent items 23a or 28a-f show 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Washington County Hagerstown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21740 U.S.A. 344 Nottingham Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Force 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. Homemaker Personal Residence 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clarence Hartman Elizabeth Ann Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clarence M. Horning-husband 344 Nottingham Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cedar Lawn Mem. Park 5-7-2012 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ NOX disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** WIE Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, physician and s the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical RESPIRA FAILURG Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Linknown 9 Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FAIUME 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 1 မ 1 Propatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after ueaun.

To the Funeral Director: After t Natural 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🐔 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole Perrotte 11116 Medical Campus Rd. Hagerstown, Md. 21742 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Mav Day Physician/ 2012 Year Edward Hurley 9:38 D. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Dorchester Cambridge 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign Funeral Days 1 X M 2 🗆 F Min. July 9, 1923 $ilde{\mathsf{Mary}}$ v1and 218-16-8181 88 Yrs. Director Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 525 Glenburn Avenue 21613 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. er than "natural", or iter the Medical Examiner Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ∐ Yes If Yes, Give white 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) unknown College (1-4 or 5+) laborer farming other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertie Harris Benjamin Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 East Appleby Ave., Cambridge, MD 21613 Wendy Wright daughter Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State 5/3/12 Crematory of Delmarva Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ dementra Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by athleroscieratic vascular Division of Vital Records, 1 Wes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performed? this certificate 1 🗌 Yes eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical tocertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier HOO 59973 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Registrar DHMH 17 Rev 7/2009

State

atricia

31. Date filed (Month, Day, Year)

03

ohnson

Box 68760

P.O.

100

Bramble

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michael Lee Hagadorn 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 23,1960 Wilcomic S If Under 24 H/s. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 216-76-9839 Min **Director** 1**X**□ M 2 □ F 51 Yrs. Maryland 28a-f show aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 No MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 21643 4846 Milligantown Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Logistics 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Martha Dukes Alva Hagadorn, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Smith/Mother 412-15 Liberty Rd., Federalsburg, MD 21632 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/07/12 Federalsburg, MD Crest Cem. Hill 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ MAHGNANT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 as the l attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ó in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No detached the g Unknown Division of Vital Records, P.O. been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No မ Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence After this filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ρ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/802 6 Hulpy 130 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 04 2012 Registrar

DHMH 17 Rev 06-2011

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Baltimore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Dispositio 1 ☒ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐	emation 3 🗌 Rem	oval from Stat	e ce	lace of Dispo emetery, cren of Ho	natory or oth	ner place		May	5, 012		ocation - City ver Spr			
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. Box 68760	Attending Physician: The law requires that the death certificate be extending Physicians to the funeral director, page 2 should be detached for use as the bur						Ectopic production of the contract of the cont		′		20	23d. Date of de Month			/ ay Year		
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on of \	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifical completely filled in by the funeral director,	Certificate: T	27. Manner of Death 1 Natural 5 □ 2 □ Accident	Pending Investigation	Ba. Date of inj (Month, Da	ury	ER/Outpatien 28b. Time of injury		c. Injury work?	at	28	e 5 🗀 Hesio		3 ☐ Other (Sc ry occurred	ecity)		
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	e Hosp 24 hou e Funei detely fi	Medical	(Check 2 □ Me	ertifying Physician edical Examiner: C ertifying Nurse Pra	n the basis of	examination	and/or invest	igation, in my	y opinior	, death oc	curred at the	ne time, date a	nd place	e, and due to the	e caus	e(s) and manner stat	ted.
	vithir Vothir	-	29b. Signature and title of		1 -		y wiewied ge,		License		o and place	, 410 000 10	29d. Da	ite signed (Mo	nth, Da	y, Year)	
			30. Name and address of	person who completed Delist	1 1				town	Road	l, Be	thesda	, MI	20814			
	Stat Registra	.ᠸ	31. Date filed (Month, Day,	Year)			par										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G929 7/20/2012 JH State of Maryland / Department of Health and Mental Hygiene 5935 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Janet Louise Johnson 2012 1:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington County Hagerstown Secial Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan. 30, 1932 Davs Hours 334-26-8902 Director 1 🗆 M 2 💢 F 80 Illinois Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits at Director notified 28a-f Maryland Washington County Hagerstown 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be Funeral 23a 20009 Rosebank Way 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Race - American Indian, Black, White, etc. 11. Marital Status ian "natural", or ite þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the Social Worker School System permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Hildur Tinberg Martin Henry Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10107 Quinby St. Silver Spring, MD 20901 Debra L. Nelson-niece Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Smithsburg Crematory | 05/09/2012 | Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or boart failure. List only one cause on each line. nterval Between nset and Reath Immediate Cause (Final Physician/ Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Encephelo helly Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit ununua and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Yes 2 No 9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for Month Year Day Pregnant at time of death ed by the a 9 Unknown P.O. ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 1 No 1 Yes Yes 2 filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 2 1 No Other: မ 1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 4656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 16MD HM BUTOWN 1190 5 HMM MT MISTWA State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ April 30, Day 2012 Rosella Mae Jordan 10:22 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Skilled Nursing Solomons Calvert 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Yea Oct. 21. 1 **Funeral** 9. Birthplace (State or Foreign 1 - M 2 XX Months Days Hours 86 Director 534-24-1945 1925 Spokane WA Usual Residence of Decedent Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Calvert Solomons 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11750 Asbury Circle Room 211 20688 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2XX No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Home maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence Eckhart Elizabeth Calavan permit. Page 1 and 2 should to Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Mitchell - Daughter 8115 Tucker's Trail, Owings, MD20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May I Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 2012 ^{22. Name and Address of Facility} Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 21. Signature of Funeral Service Ergler 8200 Jennifer Lane, Owings, MD Amanda M. 23a. Part +. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No _ Yes Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Suite 310, Prince Frederick, MD 20678 Hospita John 110 32. Registr State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 26 Physician/ Harry J. Kroll 2012 11:55 pm Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Emeritus Senior Living Potomac If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 225-12-0806 **Director** 1 🕱 M 2 🗆 F 92 Yrs June 11, 1919 Virginia Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director 1 🗌 Yes 2 🎗 No Maryland Potomac Montgomery 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? Funeral 20854 U.S.A. 11215 Seven Locks Road, #209 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \(\sum \) No 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify. "natural", White WWII Completed ge 1 and 2 should be filed within 72 houn it of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Business Own Locksmith 2 should be filed with h and Mental Hygien 7 is marked other tl 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ida Wolfe Joseph Kroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 36963 Charlestown Pike, Hillsboro, Virginia 20132 Michael Oxman/Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 X Removal from State injury or Department of Important: If any injury or once. King David Mem Grdns 04/29/2012 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine buria transit that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 X No has within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Sentor Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending Natural work? Accident
Suicide 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

15245 Shady Grove Road, Rockville, Maryland 20850

D0069800

April 27, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15938 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 Karacki Loren 29 <u>April</u> 4:43 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year) Aug. 2, 1935 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min 389-32-4404 76 1 X M 2 D F Director Wisconsin Usual Residence of Dece 28a-f show at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Rockville Maryland Montgomery 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 7232 Grinnell Drive 20855 United States death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 □ No 01-58 /
If Yes, Give 07-58 Black, White, etc. 0 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: 3 Widowed 4 Divorced 07 - 58Completed White Year or Dates and Mental Hygiene.
Is marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Bureau Elementary/Secondary (0-12) College (1-4 or 5+) 5+ of Prisons Research Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Peter Karacki Karolina Kretavicius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7232 Grinnell Drive, Rockville, Maryland 20855 Susanne S. Karacki (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other planey
Dulaney Valley
Memorial Gardens 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State May 4, 2012 Timonium, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Funeral Service Licenses (M00689)10 East Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of read failure. List only one cause on each line. Interval Between Onset and Death Physician/ C-2 Fracture disease or condition Dime Medical resulting in death) mD Due to (or as a consequence of) **Examiner** Hypernatremia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ¥ Cardiovascular Disease and Due to (or as a consequence of): resulting in death) Last ΄Σ attending physician Physician/Medical コントン・コンション・インターフ、インターファーイン・インタン Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Parkinsonism 1 Yes 2 XNo 3 Probably 4 Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy aracki, Loren, performed certificate 2 🗌 No 1 Yes Yes 2 X N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 X Yes 2 🗌 No ၉ 1 M Inpatient 2 DER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🔀 No 2 X Accident Apr.14,2012 12:00 a^M Fell down six stairs Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide Place or name building, etc. (Special Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7232 Grinnell Dr., Rockville, MD 20855 determined Medical

completely 10+1 State 29a. Certifier

(Check

only one)

2 ∐ 3 □

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAY 03 2012

Kimberly Beth Zuzak, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number 68169

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	_	= State Registrar	The solution is	4)		Cei	tificate of	Death	1	Reg. N	. 20	12		5939	
Physicia Medic		Decedent's Name	Charles	•	KENNE	Y, SR.			2. Date of De Month		2012	Year		e of Death	
Examine				e street and number) iott Driv				or Location of Death	1	40	c. County o		Death ngton		
Funeral Director		5. Social Security No. 215-72-9.		Sex 7. A		ast birthday) 54 Yrs.	If Under 1 Year Months Days		8. Date of Bi	rth ay Year)	1958			ate or Foreign	
ryland -f show ied at	Director	Usual Residence of 10a. State Maryland	Decedent 10b. County Washing	ton		y, Town or Lo								e City Limits	
th with the Maryland ms 23a or 28a-f show must be notified at	eral Dire	10e. Street and Nun	nber	 Liott Driv			10f. Zip Code 2174	2			itizen of Wh			163 2 🗆 140	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho is marked other than "natural", or items 23a or 28a-f sho is amafic event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status	ied 2 🛚 Married	12. Was Decedent Armed Forces' 1 13 Yes 2 If Yes, Give Year or Dates.	Ever in U.S	S. 13. Y	Was Decedent of I f Yes, specify Cub I ☐ Yes 2 🖾 N	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	pecify Yes or No- o Rican, etc.)		14. Race - American Ir Black, White, etc. Specify: white			l,	
e filed within 72 hour ital Hygiene. ed other than "natu event, the Medical	Completed	(Spe	15. Decedent's cify only highest gonday (0-12)		5+)	(Give	O NOT use retired	during most of word)	king	16b. Kind of Business Industry			lustry		
d be filed wit fental Hygie irked other itic event, th	To Be C	17. Father's Name (er Kenney,	Sr.		pressmar	18. Mother's Nan	ne (First, Middle chel Lou	, Maiden	Surname)				
and 2 should by Health and Mer Health sand Mer Her traumatic			Kenney -			1284	2 Little	t and Number or Ru Elliott		pt 2	, Hag	gerst	town,		
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		4 Donation	Cremation 3 of 5 Other (Spec		_ C	emetery, crer serstov		tory May	7, 2012		gerst			yland	
permi Depar Impor any ir		21. Signature of Fur	eral Service Lice	Min	nh		Name and Addr 5 East V	ess of Facility N Vilson Bly	Minnich					d 21740	
Physician/ Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	nplications that cause one cause on each lin	re.	de	er the inode of dy	ng, such as cardiac	or respiratory a	rrest,				imate Between Ind Death	
Examiner	ner	Sequentially list coif any, leading to imcause. Enter Under	nditions,	b. Due to (or as	nic	he	eart c	liseasus	•			_	Chr	vnic	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 0 9 Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of c	ıl death 3 □	Ectopic pregnar Other (specify) _	ncy			23d. Date Mont		ery Day	Year	
v requires that the de been signed by the should be detached	ا ۾	Part II. Other signif	icant conditions	contributing to death	but not res	ulting in the u	nderlying cause g	iven in Part I.	23e. Did 1		use contrib			of death?	
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ding Phy The After this funeral d		27. Manner of Death	n 5 ☐ Pending	28a. Date of inj (Month, D	iury	28b. Time of injury	28c. Inju	ry at rk?	ome 5 Resi 28d. Describe						
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2:	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investigation 6 Could not determined	be 28e. Place of In	jury - At ho tc. (Specify	me, farm, str	eet, factory, office	Yes 2 No	28f. Location (City or To			or Rural	Route Nu	umber,	
To the Hospital within 24 hours a To the Funeral Completed filled	Medical	(Check 2	Medical Exar	ysician: To the best on niner: On the basis of rse Practioner: To the	examination	n and/or inves	tigation, in my opir	ion, death occurred a	at the time, date	and place	e, and due t	to the cau	use(s) and	manner stated.	
To the within To the comp		29b. Signature and	-	m			29c. Licens	se number			ate signed (
		30. Name and addre		completed cause of	death (Item	2 a) (Type, F		martin	sbure	1,	w	2	54	0(
State Registra	e r	31. Date filed (Mont	MAY 08	012 32. Fr gist	rar's Signat	ture	W	•		-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amantha Rae i		1- For State		nent of l cate of l		Mental I		20	012 1594	
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	Cortine		Journ		2. Date of Dea		3. Time of Death	
edical Exami		Samantha Rae Kelly					Month May 6, 20		0002 nrs	
		4a. Facility Name (if not institution, give street and number) 17734 Rench Road		4b	. City, Town, or L Hagerstown	ocation of Dea	th	4c. County of Washing		
Funeral			(In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24H Hours M		,	Birthplace (State or Foreign	
Director		648-03-7318 1_M 2\hat{X}F	17	Yrs.	Moritino Days	riodis ivi	June 2	23,1994	MawnyMexico	
any		Usual Residence of Decedent 10a. State 10b. County 1	10c. City, Town	n or Location	n		. <u> </u>		10d. Inside City Limits	
.	Ļ	Maryland Washington		F	lagerstow	٧n			1 Yes 2 No	
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?	
with the Maryland ns 23a or 28a-f sbo be notified at once.		17504 Stone Valley Drive			2]	L740			USA	
th with cerns 2 it be n	Yvitte, etc.) Write, etc.								- American Indian, Black, , etc.	
ter dea									White	
hours afte "natural" Examine	d b	15. Decedent's Education (Specify only highest grade comp	oleted) 16a	. Decedent's	Usual Occupatio	n (Give kind o		16b. Kind of Bus		
136 hin 72 ho e. than "n edical Es	lete	Elementary/Secondary (0-12) College (1-4 or 5-	+)	auring mos	t of working life. [etirea)			
5-0036 led within 72 hours after Hygiene. I other than "natural", the Medical Examiner.	Completed	12 17. Father's Name (First, Middle, Last)			Student		ne (First Middle	Maiden Surname)	Education	
21215-003) ould be filed within i Mental Hygiene. marked other thi	Be C	Keith Edward Kelly					•	Reynolds		
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the <u>Medica</u>	T ₀	19a. Informant's Name/Relationship (Type, Print)		_		and Number o	Rural Route Nu	mber, City or Town		
MC 2 slath arem		Jonna Vinci - Mother 20a. Method of Disposition			Stone Va on (Name of ceme		rive Haq		Maryland 2174	
Baltimore, MD 21215 pennic Pages I and 2 should be file Departie. Pages I and 2 should by Important: If them 27 is marked of injury or other traumatic event, the		1 XX Burial 2 Cremation 3 Removal from State	e crema	atory or othe	r place)					
Itim iit. Pa artmen ortant		4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee	Green.		lem. Park				msport, Maryland	
Den Den iii	425 S. Conococheague St. Williamsport									
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	he death. Do r	not enter the	mode of dying, s	uch as cardiac	or respiratory ar	rest, shock, or hea	Approximate Interval Between Onset and Death	
Examiner	Multiple Interior									
		Sequentially list conditions, b	quorioo ory.							
	iner	if any, leading to immediate Due to (or as a consect cause. Enter Underlying Cause	quence of):							
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	quence of):							
68760, certificate be executed nding physician and ise as the burial - transit	edical	d. UNPENDED AMENDED								
'60, ate be ohysici		IF FEMALE: 23c. If yes, outcome	e of pregnancy	/				23d. Date of o	delivery	
cath certificate attending phy	ian/	23b. Was decedent pregnant in the past 12 months?	ann of death		_	Ectopic preg	nancy	Month	Day Year	
Box te death of the atten ted for us	Physician/M	1 Yes 2 No 9 V Unknown		○ Uthe	(Specify)					
수 한 한 한	by P	Part II. Other significant conditions contributing to death	but not resultir	ng in the un	derlying cause giv	/en in Part I.			bute to the cause of death? Probably 4 Unknown	
امَ ﷺ ق							24a. Was		Vere autopsy findings available	
cords law requ has been e 2 should	Completed							psy pr prmed? de	nor to completion of cause of eath?	
tal Rection: The certificate ector, page	ပိ	25. Was case referred to medical			26 Place o	of Death (Chec		2 No 1	Yes 2 No	
Vital ysician: his certif director,	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatien	t 2 ER/0	Outpatient		M	ing Home 5	Residence 6	Other: Scene	
27. Manner of Death 28a. Date of Injury May 6, 2012 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred Passenger auto fixed object col										
Sior Attend death. xtor:	catic	2 Accident Investigation								
Division of Vital Records, piral no attention of team. The law requirers after death. After this certificate has been stilled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could not be determined (Specify) Local		rarm, street,	ractory, office but	ilairig, etc.	or Town,		er or Rural Route Number, City own, MD	
Hospi 24 hou Funer rtely fil		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, de				nd due to the cau	ise(s) and manner	as stated.	
To the Hor within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	ination and/or	investigatio			at the time, date			
	2	29b. Signature and title of certifier			29c. License O.C.M			May 6, 2012	ed (Month, Day, Year)	
		30. Name and address of person who completed cause of de	ath (Item 23a)					, , , , ,		
N-6		Patricia Aronica-Pollak MD. Assistant Me			00 W. Baltim	ore Street,	Baltimore, M	ID 21223		
Si Regis	ate	31. Date filed (Month, Day Year) 32. Registrar's	A	1	No.					
- Kegis	11:11	A SAME AND	William William	A STATE OF	क्रां का र					

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			For	State of Marylar				ınd Mental	Hygien	e	0 1	- 01			
			State Registrar	Cei	tificate of L	o. 201	2	<u> </u>							
	Physicia	ın/	1. Decedent's Name (First, Middle, La	,				Mont		ay Year	3. Time o	of Death			
-	Medic		THELMA JEAN 4a. Facility Name (if not institution, give			4b. City, Town, or	Location of	IAPRT			11:55	<u>p</u> "			
	Examin	er	FREDERICK MEM			FREDERIC		Dodin		REDERIC					
	Funeral		Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Date of Min. (Mont	of Birth	g. F	irthplace (State	or Foreign			
	Director			□ M 2 🔀 F 76	Yrs.	IVIOITIIS Days	Tiouis	Oct.	h, Day, Year) 15, 1	.935 Vii	ginia				
	nd how at		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					10d. Inside C	Lity Limits			
	faryla Ba-f s tified	Director	Maryland Frederi	ick	Walkers	sville					1 X Ye	s 2 🗆 No			
	the A		10e. Street and Number	- 71		10f. Zip Code	700		10g. C	S.A.	Country?				
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	r iten		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of Hi f Yes, specify Cuba				14. Race - An Black, Wh					
336	s after al", o Exam	d b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🕅 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates.		I ☐ Yes 2 🙀 No	Specify:			Specify:	White				
2-0	hours natur lical I	lete	15. Decedent's E	Education		ent's Usual Occup		- H-	16b.	L Kind of Busines	s/Industry				
21	nin 72 ne. han " e Mec	The state of the s									Componi	7			
121	d with tygier ther t nt, th	Be C	17. Father's Name (First, Middle, Last)		Pri	iter	10.04.0				Company				
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	To E	Homer Goines				Li.	r's Name <i>(First, Mi</i> llian Ho	undsch	iell					
aryl	nd Me s marl		19a. Informant's Name/Relationship (1	Type, Print)	19b. Mailir	na Address (Street a	and Number	or Rural Route N	umber. City o	or Town, State, 2	Zip Code).				
Š	d2shaltha altha 27is ertra		Lili Geisler, da		8810	ng Address <i>(Street a</i> Challe ng	e Wal	k, Walke	rsvill	e, MD 2	21793				
ore	of He		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	Pomoval from State	cemetery, crer	sition (Name of natory or other plac	e)	Date	- 1	_ocation - City	or Town, State				
ij	Page tment tant: It jury or		4 Donation 5 Other (Special	fy) Cre	agerst	own Cemet	ery M				town, M)			
Bal	permit. Page 1 a Department of B Important: If its any injury or of		21. Signature of Funeral Se Liceh	see M002	55 1 0	Keend Addres 06 East C	nd Ba	sford PA St., Fr	Funer ederic	al Home	2 1701				
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause on each line.												
	Physician/		Immediate Cause (Final disease or condition	a. FAILULE Die to (or as a consec	70	THALVI	-				Onset and				
J.	Medical Examiner		resulting in death)								DANK				
	v dia	Jer	Sequentially list conditions,	b. PMEUM							17.	(-			
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09	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical		d							-				
687	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregn	ancy										
Box 687	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fet	al death 3	Ectopic pregnand Other (specify)	у		İ	23d. Date of o Month	,	Year			
B.	the de ry the ached	hysi	1 ☐ Yes 2 🔼No 9 ☐ Unknown	g 🗌 Unknown		(-)									
P.O.	that the		Part II. Other significant conditions	ontributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacco	use contribute	to the cause of	death?			
ds,	quires en sig ould b	ted							1 Yes 2	2 No 3 🗆	Probably 4	Unknown			
cor	aw rei as be	Completed by						24a.	Was an autopsy	prior t	autopsy findings o completion of	available cause of			
Re	ician: The law certificate has rector, page 2	Con						1 🗆	performed? Yes 2 1	death'	es 2 No				
ita	ician certifi rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		Oth	er:	n (Check only one)		- 100		-			
of V	r this eral di	e: To	27. Manner of Death	1 Appatient 2 28a. Date of injury	28b. Time of	nt 3 🗆 DOA	4 ∟ Nur	rsing Home 5 28d. Desc	Residence ribe how inju		ecify)				
ou c	nding ath. r: Afte ne fun	icat	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigatio	(Month, Day, Year)	injury	M 1 🗆	? Yes 2 🗌 I								
Division of Vital Records,	or Atte after des Director	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specit		eet, factory, office			ion (Street a		Pural Route Num	ber,			
Ö	Hospital or Attending I 24 hours after death. Funeral Director: After stely filled in by the funer														
	Hosp 24 ho Fune etely f	Medical	(Check 2 Medical Exam	vician: To the best of my know	on and/or invest	tigation, in my opinio	on, death occ	curred at the time,	date and plac	e, and due to th	e cause(s) and m	anner stated.			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Σ	29b. Signature and title of certifier	se Practitioner: To the best of		20c License	number	-	204 D	ate signed (Mou					
						200	621	13	S	1/12					
	3		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, F	Print 200	75 4	01- 11.	0/2	7					
			BOCA JUM, M	V 196 TJ)(Leve,	+ illy	valle	C, Mb	217	07					
	Stat Registra	ı.e	31. Date filed (Month, Day Year)	2012 32. Registrar's Signa	ature A	barker									

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #8, PER FH, G961 3-30-15 SM State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ Medical Examiner 8. Date of Birth 24 Hrs. Birthplace (State or For Country) **Funeral** 568-36-2148 82 NY Director 1 □ M 2 **X** F 9-18-1929 28a-f shov aţ 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 XNo MD Brookeville Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20833 18637 Shady View Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status o. by 1 Never Married 2 K Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Office Clerk Insurance permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If Item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert A. Anderson Elizabeth Gertrude Dirksen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18637 Shady View Lane, Brookeville, MD 20833 19a. Informant's Name/Relationship (Type, Print) Joe H. Kim/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State May 5, 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Colemputeral Februices, P.A. Rd., #100, Rockville, MD 20853 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death shock, or heart failure, I Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine rany, reading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 No Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ၉ ☐ ER/Outpatient 3 ☐ DOA Inpatient After this Manner 1 Natural Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? injury 5 Pending 2 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signatu CTICE PHILIP DRI strar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Nancy Diane Kline 2012 9 4:44 A M May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Smithsburg 73 West Water Street Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Aug. 13, Months Days Hours Min Year) 214-54-0595 1 □ M 2 🛣 F 63 Yrs. 1948 Pennsylvania **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Maryland Washington Smithsburg 1 X Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 73 West Water Street 21783 U.S.A. ural", or items? Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 🗌 Widowed 4 🗌 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) It of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teller Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alvey M. Davis Bertha E. Fahrney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Richard E. Kline, Jr. 73 W. Water St. Smithsburg, Maryland 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ot May 1 Burial 2 X Cremation 3 Removal from State 11, Smithsburg, Maryland 4 Donation 5 Other (Specify) Smithsburg Crematory 2012 Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 22. Name and Address of Facility 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ months disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Else United hybrid Cause (Disease or linjury Due to (or as a consequence of): Examin attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? signed by the atte Month Day Year Pregnant at time of death Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should been Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 No Yes Hospital or Attending Physician: 24 hours after death. after death.

Director: After this certification of the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 \square Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be To the Hospital or Atta within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred Louise Linster May 10 2012 11.35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12853 Owens Drive Waldorf Charles If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Hours (Month, Day, Year) 212-22-4128 Director 1 □ M 2 🗓 F 88 03/27/1924 Washington, DC Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12853 Owens Drive 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: 3 X Widowed 4 □ Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Administrator Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Wilber L. Hill Catherine L. Fisher 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan M. Winter 12853 Owens Drive, Waldorf, MD 20602 injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Brinsfield-Echols Crem.5/11/2012 4 Donation 5 Other (Specify) Charlotte Hall, MD 21. Son Jure of Funeral Service Licenses any in Brinsfield-Echols F.H., P.A. #M00817 B0195 Three Notch Rd., Charlotte Hall, MD 20622 25a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ CEREBROVASCULA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner YRS HUDERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence 5); To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THRIVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performe death? 1 ☐ Yes 2 🔯 No 1 Yes 2 No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 🔀 No |요 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined City or Town, State) Medical 🛱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one 29b. Signature and title of certifier our 082 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALDURF MD PAULMEllow CT

DHMH 17 Rev 06-2011

Registrar

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1 8 2012

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day <u> Gloria R. LaMotte</u> April 30 2012 12:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Numbe 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min **Director** 1 M 2 😿 F 438-68-5282 82 Dec. 19, 1929 Usual Residence of Dece Louisiana hohs 10a State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director 28a-f 1 X Yes 2 No D.C. Washington ms 23a or must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 United States 308 Oglethorpe Street,North East death \ 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 2 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify. "natural" Completed 3 X Widowed 4 Divorced Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ **Educator** Education traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! မ Harry A. LaMotte, Sr. Inez Baranco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau 308 Oglethorpe Street, North East Washington, District of Columbia 2001 Nettie Nichols/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a Burial 2 Cremation 3 Removal from State 05/04/2012 Silver Spring, Maryland Other (Specify) Gate of Heaven f Funeral Service Lic 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 7400 Georgia Avenue Washington, District 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final BREAST CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending physicia the bur P.O. Box 68760 as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Tes မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending М Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 31. Date filed (Month, Day, Year) 03 2012

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29b. Signature and title of certifier

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

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Examine			n Bree	ze Assist	ed Livi		4b. City, To	Owi	ngs				c. County Ca	lver		
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physici the bu				d									_	\pm		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	— I	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 X 9 ☐ Unknown	nonths?	1 🗌 Live	tcome of pregnar Birth 2 Feta nant at time of d	Ideath 3 🗌	Ectopic pre		/				23d. Dat Mo	te of delive	ery Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 30°ay 2012 Margaret Lloyd 9:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2501 Shelley Circle Apt. 2A Frederick Frederick Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 478-16-8980 90 Director 1 M 2XXX Jan. 17, 1922 Iowa Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a State Director Maryland Frederick Frederick 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be r Funeral 2501 Shelley Circle, Apt. 2A 21702 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify "natural", **¾**Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Nurse Practitioner Nursing alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked Walter Aird ပ Pearl Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Puryear/daughter 7419 Piney Branch Road Takoma Park, Maryland 20912 other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XX remation 3 Removal from State ö Department Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 5/4/2012 Baltimore, Maryland Signal of uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bcell Physician/ ara disease or condition Medical resulting in death) Due to (or as a consequence of): 0 **Examiner** ailure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit roke Due to (or asia consequence of): resulting in death) Last Mbrillation Physician/Medical 10 Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Month been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a Was an autopsy performed? Yes 2 No page 2 Director: After this certificate has I or Attending Physician: after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Manper of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending work 1 ☐ Yes 2 ☐ No Accident filled in by the Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month. Day, Year) 0005506

State Registrar

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31. Date filed (Month, Day, Year) 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bertha Dunlap Minus April 2012 9:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Oxon Hill Alexander Drive If Under Hours Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year 8. Date of Birth g, Birthplace (State or Foreign **Funeral** Months Davs Min (Month, Day, Year 11/11/195 1 🗆 M 2 🔀 F 60 578-70-5651 Washington, DC Director Usual Residence of Decedent 28a-f shov 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Prince George's Oxon Hill 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20745 United States 9 Alexander Drive death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc o. 1 Never Married 2 K Married Completed by Yes 2 No Yes, Give 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Afriçan Specify: "natural", 3 Widowed 4 Divorced Year or Dates American 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16b. Kind of Business Industry Edward Waters 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working

Office DO NOT use retired Vice President (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) College Academic Affairs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nina Mae Gilliam James Dunlap 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9Alexander Drive, Oxon Hill, MD Reginald Conway Minus-husband 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Quantico Nat'1. Cem. 4/30/2012 Triangle, Virginia 22. Name and Address of Facility McGuire Funeral Service, Inc. Signature of Funeral Service Licensee Thomp inde 7400 Georgia Ave., N.W. Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pancreas Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): B Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical death certificate be Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 wonths? ō 5 Other (specify) Pregnant at time of death the g Unknown g 🗌 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ! by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed? Yes 2 No certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this pleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 within 2
To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 April 26, 2012

State Registrar Martin Weltz, M.D.
31. Date filed (Month, Day, Year)

MAY 03 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

72. Registrar's Signature

7525 Greenway Center Drive, Greenbelt, MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Daden Month Physician/ AM Medical 4a. Facility Name (if not institution, give areet and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Candle Light Cove Easton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Days Hours 168-09-7187 Director 95 1916 Pennsylvania June Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland items 23a or 28a-f shoner must be notified at 10d. Inside City Limits Director MD Talbot Easton 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21601 106 West Earle Avenue United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: "natural", Completed 3 ★ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file alth and Mental H ၉ Fleeta Laurene Ogden Leids-Noel Eugene Leidig Leids other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important; If item 27 is any injury or other trau Craig Walsworth/ Esquire 9331 Martingham Circle, St. Michaels, MD 21663 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) May 9, 2012 Denton, Maryland Denton Cemetery 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee Michael 7 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Obstruction Immediate Cause (Final BOWE Physician mall disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to in realist cause. Enter Underlying Our to for as a nonsequence of Exami executed Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year Pregnant at time of death
Unknown ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed page 2 should Fibrillation Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 🗌 No I ☐ Yes 1 Yes 25. Was case referred to edical Be 26. Place of Death (C - ck only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending r death. 1 Yes 2 No filled in by the f Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide af er within 24 hours a

To the Funeral C

completed filled Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title License number signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

186

completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2872 0615 Rodney Halstead Mills, Ir. 09 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 🗆 Months Hours May 09, Year 1924 Connecticut 87 046-20-5599 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Gaithersburg 1 X Yes 2 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a or ner must be n Funeral U.S.A. 407 Russell Avenue, #214 20877 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status the Medical Examiner 1 X Yes 2 No 1943-If Yes, Give ō ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced 1946 Caucasian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Federal Reserve Board Economist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Eunice Tiffany Cole Rodney Halstead Mills t. Page 1 and 2 should be treent of Health and Men rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 134 Chamounix Road, Wayne, Pennsylvania 19087 Chris Mills - Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory: 05/04/2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral & Crematio 21. Signature of Funeral Service Licensee monton 1401524 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death shock, or heart failure. List only one cause on each line Interval Between 0 Immediate Cause (Final Physician/ minute 0 Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month 5 Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 🙀 No To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 _2 🕱 No 1 Inpatient 2 KER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 5 Pending injury ✓ Natural Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 2012 TI Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 20850 Rockville, MD center rett Camma Medical Drive

DHMH 17 Rev 7/2009

State

Registrar

MAY 03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Myrna Ruth McManus Mac Medical 2017 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Meritus Medical Center Washington County Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 236-32-7460 (Month, Day, **Director** 85 1 XM 2 🗆 F Aug. 6,1926 Pennsylvania Yrs Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. inside City Limits Director Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Manor Dr. Apt 102 21740 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 XWidowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Executive Secretary 12 Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 109 Manor Dr. Apt 102 Hagerstown, MD 21740 Kathleen F. Claggett-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State Smithsburg Crematory 5-4-2012 4 Donation 5 Other (Specify) Smithsburg, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter r e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Due to (or a la consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a consequence of the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 attending for use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signe should be Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Yes 2 🔽 No 1 Tes tal or Attending Physician: The safter death.

al Director After this certificated in by the funeral director, p Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗷 No Other: 1 № Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital of the hours a uneral D Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practilities of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within To the 29b. Signature and title of certifier 29c. License number 500f0027 Amsler 2012 Hagerstown Many land 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TILLO (ampus Road State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month McCorkle May 2012 6:12 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Glade Valley Center Walkersville Frederick Social Security Number 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 428-40-5848 Months Days **Director** 1 M 2 K F 91 Yrs September 19, 1920 Mississippi Usual Residence of Deceden 28a-f show with the Maryland 10c. City, Town or Location Director Examiner must be notified Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1407 Key Parkway, Apartment C304 21702 United States of America Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Newton Griffin Molly Whitworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -lealth If item 27 Pegge Fisher / Daughter 1407 Key Parkway, Apartment C304, Frederick, Maryland 21702 20a. Method of Disposition Department of H Important: If ite any injury or oth once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other (Specify) Entombment Mount Olivet Cemetery May 3, 2012 Frederick, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home** M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death neumonitis Physician/ mostron disease or condition resulting in death) Gins Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Year signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Certificate: To Be Completed 1 Yes 2 X No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural injury work?
1 Yes 2 No 5 Pending Accident Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 5-1-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 Toil House Ave. Zaridi MO 801 31. Date filed (Month 32. Registrar's Signature State Barks

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Day RUSSELL KEITH McCONNELL May 10:35a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital Oakland Garrett Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F 8/23/1935 WV Country) 235-54-2774 76 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location ural", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director WV Preston Terra Alta 1 Yes 2 X No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 9726 Cranesville Road 26764 U.S. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Saltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 'natural", 3 Widowed 4 XDivorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education 12 5+ Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) R. L. McConnell Norma Curnutte McConnell permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chiquita Sweitzer 9669 Cranesville Rd, Terra Alta, WV 26764 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Terra Alta Cemetery 5/4/2012 Terra Alta, WV 21. Signature of Full and Service Licens 22. Name and Address of Facility any Arthur H. Wri 105 Highland A ght ve, Funeral Terra A aux WV 26764 23a. Part 1 Enter the disease, of comp cations that caused shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) PA Medical Due to (or as a col equence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of) sician and burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Day Month Pregnant at time of death Year 5 Other (specify) ed by the a detached f g Unknown Linknown Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an SBL page 2 s Hospital or Attending Physician: The certificate director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending death 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier Wertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatuj

State Registrar 30. Name a

31. Date filed (Month, Day, Year)

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Oakland

21550

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who completed cause of death (Item 23a)

MD

Buckingham

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician ayne Robert Mosser 09 9019 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Garrett 1027 Accident- Bittinger RD. Accident 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 1X M 2□ F 3/21/1940 Marvland Director 215-36-8431 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2 XNo Director Accident MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 U.S.A. 21520 1027 Accident-Bittinger RD Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Owner/Operator 12 f Health and Mental Hygitem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Kahl L. Alberta Ε. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21520 19a. Informant's Name/Relationship (Type. Print) 1027 Accident-Bittinger Rd.Accident, Evelyn M. Mosser/ Wife 20b. Place of Disposition (Name of Z 1909 Pery, Cremeting Property) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/5/12 Cemetery Accident, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Newman Funeral Homes P.A. 179 Miller St., Grantsville, MD 21536 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) obstructive ChRONIC YRS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month ľo. in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No o 9 Unknown Division or Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home ★ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 Tyes 2 TNo death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ie Hospital or Attendi 24 hours after death. Ie Funeral Director: A within 2.

> State Registrar

ONALD 31. Date filed (Month, Day, Year)

29b. Signatur

30.1

MEMORIAL DR DAKLAND MD 2/570 TOKER m) 1027 22. Registrar's Signature

d cause of death (Item 23a) (Type, Print)

29c, License number

30035

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 04723/2012 1557 PATRICK CHARLES NORRIS, SR. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University of Maryland Medical Ctr Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 06/22/1939 218-34-7103 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No North Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 5901 Montrose Road, #N1608 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, led Forces? Yes 2 \(\sigma\) No \(1965-\) Black, White, etc. ģ 1 Never Married 2 XMarried 1X Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black Completed 1968 Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) Technician Real Estate 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Magdeline Dorsey 19a, Informant's Name/Relationship (Type, Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 5901 Montrose Road, #N1609, North Bethesda, MD 20852 Mary Vanessa Womack-Norris/ other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl cemetery, crematory or other place 1 \square Burial 2 $\!X\!\!\square$ Cremation 3 \square Removal from State 05/02/2012 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Sv : Hanover, MD 22. Name and Address of Facility Snow len Funeral Home 21. Signature Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pulmonary Embolus Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami ransit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): ending physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jō Month Day Year Pregnant at time of death ☐ Pregnam ☐ Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Coronary Artery Disease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a Was an cate has page 2 prior to death? autopsy perform certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No ပ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 🕅 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certi

death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Baltimore AD 2/201

29d, Date signed (Month, Day, Year) 5/01/2012

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

REPL	A	CEMEN Se T	ype or Print in B	lack In	delible In	k. Ensure	All Copie	es Are	e Legik	ole.		
		For State Registrar	State of Maryland	/ Depa	rtment of F tificate of L	nealth and i	T	Reg. No	; 2∩		1595	
Physicia Medic		1. Decedent's Name (First, Middle, Last) Adele N	NICKBARG				2. Date of D Month May	eath 2 Da	³y 2Č)1°2	3. Time of 6:30	
Examin		4a. Facility Name (if not institution, give str Hebrew Home of Grea	ter Washington		Rockvi		1	N N	. County of	omery		
Funeral Director		Usual Residence of Decedent	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D March	irth 30 ,	925	Country	York	or Foreign
Maryland 28a-f shonotified at	Director	10a. State 10b. County Maryland Montgomery		kville	9							ity Limits
with the s 23a or ust be r	Funeral D	10e. Street and Number 6121 Montrose Rd.			10f. Zip Code 2085	2		_	itizen of Wh		,	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	lf i		ispanic Origin? (Sp n, Mexican, Puerto Specify:		-	14. Race - Black, Specify:	White, etc	c.	
21215-0036 within 72 hours after giene. er than "natural", of the Medical Exam.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give ki	NOT use retired)	ation during most of wor	king		Kind of Busin		ıstry	
Maryland 2 2 should be filed v th and Mental Hyg 27 is marked othe traumatic event,	Dury by the polytical poly											
Mary and 2 shoul lealth and I m 27 is mi		19a. Informant's Name/Relationship (Type, Susan Nickbarg , C	daughter			on Ave.,	#101,	er, City or S ilv	er Spi	te, Zip Co ring	, MD	20910
altimore, mit. Page 1 and apartment of Hee portant: If item y injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State Holy	order 0		Living/0		Ch	ocation - Ci	waqa	, NY	
Ball permit Depart Impor any in		21. Signature of Funeral Service licensee	Bug (20035			ss of Facility To		У Н	ebrew	Fune	eral 0012	Home
Physician/ Medical		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. It cause of each line. Preumonia Due to (or as a consequent	Do not enter						A	Approximat nterval Bet Onset and I	ween
Examiner	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequent	ce of):						-		
6 7 7	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):								
760 ficate be g physici as the bu	Nedica	d.						_				
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal de 4 Pregnant at time of deal 9 Unknown	eath 3 🗌	Ectopic pregnanc Other (specify)	у		ŀ	23d. Date of Month			/ear
ds, P.O. juires that the signed by tuild be detach	ed by PI	Part II. Other significant conditions contri	ibuting to death but not resulting	ng in the und	derlying cause giv	en in Part I.			use contribu			
Division of Vital Records, all or Attending Physician: The law requires s after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a	Completed by						24a. Was auto perf 1 \square Yes	psy	pric	re autops or to comp ath? Yes 2	y findings a oletion of c	available ause of
ital sician: certific rector,	Be	25. Was case referred to medical examiner?	spital:		Othe	ace of Death (Chec	ck only one)					
of V g Phys er this	e: To	27. Manner of Death	1 Inpatient 2 ER 28a. Date of injury 28	b. Time of	28c, Injury	4 LANursing H	ome 5 Resi			Specify)		
ttending death. stor: Afte	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	injury		? Yes 2 □ No						
Divis spital or A lours after eral Direc		4 Homicide determined 29a. Certifier 1 XCertifying Physicia	28e. Place of Injury - At home building, etc. (Specify) an: To the best of my knowledge			date and place s	28f. Location (City or To	wn, State,)			er,
the Hos nin 24 h the Fun npletely	Medical	(Check 2 Medical Examiner	On the basis of examination an	nd/or investig	ation, in my opinio	n. death occurred a	at the time, date.	and place	 and due to 	the cause	e(s) and ma	nner stated.
To with		29b. Signature and title of certifier			29c. License D0064				te signed (A		y, Year)	
6		30. Name and address of person who com Mina Fazli, MD 6	121 Montrose R	Rd., R	ockville	, MD 20	852					
State Registra	e r	31. Date filed (Month, Day, Year) JUN 1 3 2012	Registrar's Signature	par	Red							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended #20b, per FH, FCHD, KS, 5/2/12

	1	For Stata Registrar			artment of tificate of			Reg. No.	012	1595		
	_	Decedent's Name (First, Middle, Last)			-		2. Date of Do	eath Day	Year	3. Time of Death		
Physician /Medical	_	Robert B. Neal					April					
Examiner		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town	, or Location of De	ath	4c. Cou	nty of Death			
		Kline Hospice Hous	e		Mt.	Airy		Frederick				
Funeral Director		5. Social Security Number 6. Security Number 1/20-42-5141	7. Age (<i>ln yrs. la</i> IM 2 F 67	ast birthday) Yrs.	Months Day		Irs. 8. Date of Bi (Month, D Oct.6,	ay, Year)		place (State or Foreign ntry) ryland		
2 > 32		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	cation					IOd. Inside City Limits		
aryra ehov	_	Tod. State Too. County								1 ☐ Yes 2 🛣 No		
or 28a-1 el	Di la	Maryland Frederic	ck Mid	ldletov	Vn 10f. Zip Code			10g. Citizen	of What Cour	otny?		
Die	5		1 D 1					_				
18 23	era	6809 Mountain Chure	2. Was Decedent Ever in U.S	S 13 V		1769	(Specify Yes or N		reder:			
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f ehow any injury or other traumatic event, the Medical Examinate, ust by rutilities at once. To Be Completed by Funeral Director	y run	1 ☐ Never Married 2 ☒ Marned	Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: Vietn		f Yes, specify Cu	uban, Mexican, Pu	erto Rican, etc.)	3	Black, White, ecify: White	etc.		
lural al Ex	<u> </u>	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu			dent's Usual Occ	unation		16h Kind o	WIIJ 1 Business/In			
ygiene. ner than "natura t, the Mudical E	lete	(Specify only highest grade		(Give	kind of work dor DO NOT use reti	ne during most of a	working	Tob. Kind o	1 003111633/111	loustry		
than than	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Contra			Heati	ing/Plu	ımbina		
Hygi ent, I		17. Father's Name (First, Middle, Last)	<u> </u>		OOHELA	-	Name (First, Middle			Imping		
Mental H arked ott atic ever	n	James Claude Neal				Violet	Murphy					
mari mati	= 1	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Stre		Rural Route Numi	ber, City or To	wn, State, Zip	Code)		
th ar		Judy A. Neal / Wit	Fe	6809	Mountai	n Church	Road, M	iddleto	nwn MD	21769		
Hea Other	1	20a. Method of Disposition	20b. Pt	ace of Dispo	sition (Name of		Date		on - City or To			
t: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	natory or other p	. 103	/6/2012	77 1 .		(1 1		
artme ortan injur	1	21. Signature Juneral Service/cicens				ry Inc.4		Frede	rick,	Maryland.		
Depa impo any ir once.		Jodel D	Mount	St Id	auffer 21 Opos	Funeral sumtown	Homes P. Pike, Fr	A. ederick	,Mary	land 21702		
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Medical	ner	disease or condition resulting in death)	Due to (or as a consequ	uence of):	KUML	15CM	2 Mich			nours		
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ie ie		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	Jence of):	001.0	Copre			nour's			
physician and the burial-transit		Cause (Disease or injury that initiated events										
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the bur	Ca		J									
as the		IF FEMALE:										
igned by the attending pose as be detached for use as by Physician/Mee	and a	23b. Was decedent pregnant	3c. ff yes, outcome of pregnal 1 Live birth 2 Fetaf		Bectopic pregna	ńcy		23d.	Date of deliv Month	ery Day Year		
ed fo	2	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)				MONTH	Day 160		
by the	جُ	9 🗆 Unknown										
6 g 6		Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlying cause	given in Part I.		Tobacco use o		the cause of death? bably 4 Dunknow		
s been si should I	Jet						24a. Wa		4b. Were aut	opsy findings availabl		
cate has been s page 2 should Completed	E						per	opsy formed?	death?	ompletion of cause of		
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his cert I direct	ן מ	examiner?	lospital:	ER/Outpatier	nt 3 DOA	Othor	g Home 5 ☐ Re		Other (Speci	Mouse		
ar this		27. Mann of Death	28a. Date of Injury	28b. Time o	f 28c. Ir	njury at		how injury oc	-	w tropbace		
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ai Director: After led in by the funera	100	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str	reet, factory, office	DB			umber or Rur	al Route Number,		
d in by	e	4 Homicide	building, etc. (Specify	()			City or I	own, State)				
within 24 trous atter to age. To the Funeral Director. After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com		29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kno nar: On the basis of examinal	wledge, deat tion and/or in	h occurred at the vestigation, in m	e time, date and pl y opinion, death o	ace, and due to the	e cause(s) and e, date and pla	d manner as : ice, and due	stated. to the cause(s)		
	Med	29b. Signature and title of certifier	and manner stated.		29c Lice	ense number		29d. Date si	aned (Month	Dav. Year)		
2 6 3	_	250.500	(24) 111)		1	10111	(4)	5	12/1-	7		
To the comp					1 /							
Toth		X1+. Z. 17 C	31/21/000			4410			12/10			
to to the comp		30. Name, and ddress of person who co	empleted cause of death (Item	23a) (Iyao.	Print) MD	21702			12/10			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APRIL 29 Day 2012 Year DONALD JOHN ORTNER, SR. 6:27 P M Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death
MONTGOMERY **Examiner** 4b. City. Town, or Location of Death BETHESDA SUBURBAN HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 192-30-1839 73 Director 1 ₺ M 2 🗆 F Yrs AUG. 23, 1938 MA Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD MONTGOMERY KENSINGTON 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20895 USA 4510 WOODFIELD ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White 0 1 Never Married 2 X Married þ Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working SMITHSONIAN INSTITUTION al Hygiene. d other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ MUSEUM OF NATURAL HISTORY ANTHROPOLOGIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 ABRAHAM WILLIAM ORTNER MARIE B. SCHWEITZER permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic e once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4510 WOODFIELD ROAD, KENSINGTON, MD 20895 JOYCE E. ORTNER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) MAY 4, 4 Donation 5 Other (Specify) NORBECK MEMORIAL PARK OLNEY, MARYLAND 2012 If Funeral Service FRANCE SO Address COELLINS FUNERAL HOME INC. Mater chard 500 UNIVERSITY BLVD. W., SILVER SPRING, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death NON-TRAUMATIC INTRACRANIAL BLEEDING/INTRAVENTRICULAR HEMORRHAGE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Physician/Medical Examiner Completed by The law requires has To Be

Division of Vital Records, P.O. Box 68760 , DONALD After this certificate To the Hospital or Attending Physician: Il Director: A ed in by the fi within 24 hours a

Gague stally liet or aditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): C. Due to (or as a consequence of): d.									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
		24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No								
25. Was case referred to medical	26. Place of Death (Check	only one)								
examiner? 1 XYes 2 ☐ No	Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify)								
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	(<i>Month, Day, Year</i>) injury work? ∩ M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
(Check 2 Medical Exam	sician: To the best of my knowledge, death occurred at the time, date and place, an iner: On the basis of examination and/or investigation, in my opinion, death occurred at se Practitioner: To the best of my knowledge, death occurred at the time, date and pla	the time, date and place, and due to the cause(s) and manner stated.								

29c. License number

who completed cause of death (Item 23a) (Type, Print)
ARA-NIETO, MD 8600 OLD GEORGETOWN ROAD, BETHESDA, MD 20814

D68405

29d. Date signed (Month, Day, Year)

2012

DHMH 17 Rev 06-2011

State

Registrar

12

Certificate:

Medical

29b. Signature and title

JESUS D. 31. Date filed (Month, Day, Year)

GUEVARA-NIETO, MD

MAY 03 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **PRESSER** Harriet 2012 8:12 Р Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 5417 Linden Court Bethesda Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 264-52-3294 1 🗆 M 2 💢 F 75 **Director** 29. New York Usual Residence of Deceden Aug. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20814 5417 Linden Court death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ğ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Education Professor is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rose Gudowitz Philip Rubinoff other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 230 East 48th St., New York, NY Sheryl Presser, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oti cemetery, crematory or other place 1 X Burial 2 Cremation 3 X Removal from State Beth David Cemetery 05/04/12 4 Donation of Opecify) Elmont, NY Torchinsky≈Hēbrew Funeral Home 20012 254 Carroll St., NW, Washington, DC 23a. Part 1. Saler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Ovarian Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 bours after death.

Within 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burnel. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\begin{array}{c} \begin{array}{c} \beg 1 Yes 2 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

29b. Signature and title of certifie

Coleman,

31. Date filed (Month, Day, Year) 1AY 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 1355 Piccard Drive, Suite 100, Rockville, MD

29c. License numbe

D 37142

29d. Date signed (Month, Day, Year) May 2, 2012

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20<u>12</u> Physician/ April 28, 4:00 P.M Pratt Margaret Agnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Beach Calvert 3824 15th Street 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 579-12-8921 1 🗆 M 2 🛣 F Yrs 04/28/1920 Maryland 92 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at **Funeral Director** 1 X Yes 2 No MD Calvert Chesapeake Beach 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Numbe 23a 3824 15th 20732 U.S.A. Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married Yes 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates white "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the personnel manager U.S. Government alth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Maggie Wills Robert Α. Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any injury or other trauonce. 304 East Forest Trail, Crownsville, MD Lawrence R. Pratt, Jr., son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 V Burial 2 Cremation 3 Removal from State George Washington Cemetery 5/7/12 Adelphi, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. Owings, MD 20736 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ y = AUS COMPLICATIONS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter in the past 12 months? 1 Yes 2 No Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available Be မ Medical Certificate:

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a

To the Funeral C

completely filled

	autopsy prior to completion of cause of death? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	
	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

JRW Registrar

30. Name/and address of person who completed cause of death (Item 23a) (Type, Print) F-RFT) FRICK

GFZ 31. Date filed (Month, Day, Year)

MAY

29b. Signature and title of certifier

10

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20T2 3:15 a.M Darcy Parella Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dorchester Chesapeake Woods Center Cambridge Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 220-32-0358 Director 93 1 X M 2 🗆 F Yrs July 18, 1918 Maryland or 28a-f shov 10d. Inside City Limits 10a, State 10c, City, Town or Location Director Examiner must be notified MD Cambridge Dorchester 1 X Yes 2 No 10e, Street and Numbe 10f, Zip Code 10g, Citizen of What Country? , or items 23a Funeral 21613 USA 904 Springfield Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc à 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify. "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) 10 College (1-4 or 5+) owner/operator trucking company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Tony Parella Gertrude Elzey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Bradley sister 228 Elm Town Blvd., Hammonton, NJ 1 and 2 s if Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o ō 1 Durial 2 X Cremation 3 Removal from State 5/7/12 Crematory of Delmarva Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service I 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Peath Immediate Cause (Final metastatic colon cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death the Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe atrial fibrillation, pulmonary embolism 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform page 2 death? 1 ☐ Yes 2 🗷 No 1 Yes 2 No this certificate To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer 5 Pending work? 1 Yes 2 No 1 X Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🖪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Pritirying Nurse Proditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of certifier 29d. Date soned Month. Dav. Year 29b. Signature and title 29c. License number 31 10 H44615

DHMH 17 Rev 06-2011

State Registrar and andress of person

31. Date filed (Month, Day, Year)

A. Nart D.O.

I∕oi

Cambridge, MD

21613

completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

100 Bramble St.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Cert	tificate of	Health a Death	nd Men	ital Hygiene	Reg. No.	012 1598				
Physic Medical Exan			3. Time of Death									
		4a. Facility Name (if not institution, give street and number)		b. City, Town,	OF Location	Month May 7, 2		2015 hrs				
		1235 Mount Pleasant Drive	1	Annapolis		or Death	4c. County of Anne Aru					
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Ye Months Da				Birthplace (State or ForeignNew York				
		Usual Residence of Decedent	1 XIM 2 F Yrs. 7 Yrs. 7 7 7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									
w any		100	Town or Location	on				10d. Inside City Limits				
faryland 28a-f show	Ş	MD Anne Arundel Anna 10e. Street and Number	apolis					1 Yes 2 X No				
the Ma	Director	10g. Citizen of Wha	at Country?									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 23s-f sho injury or other traumatic event, the Medical Examiner sum be coffin-	Funeral	1235 Mount Pleasant Drive 11. Marital Status 12. Was Decedent Ever in U.S.		21409 Decedent of H	ispanic Orio	in? (Specify Yes or N	USA	American Indian, Black,				
er deat	ਜ਼	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 V Divorced If Yes, Give Years 2 C 10 5	If Yes	s, specify Cuba	in, Mexican,	Puerto Rican, etc.)	White,	etc.				
ours af atural' camin	À	or Dates: 1962-196	9 1 1 1 16a. Decedent':	Yes 2 No		ind of work done	Specify:	White				
36 in 72 h ical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Offic	st of working life OI	9. DO NOT t	use retired)	16b. Kind of Busin					
d within ther the Med		17. Father's Name (First, Middle, Last)	Perso	nnel Ma	-		Governm	ment				
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	8	Harry Quigley		- 1		Name (First, Middle, 1 Maneval	Maiden Surname)					
should and Maric en	₽	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	Address (Stree	et and Numb	per or Rural Route Nu	mber, City or Town,	State, Zip Code)				
e, M l and 2 Health item 2		Erin E. Quigley / Daughter 20a Method of Disposition 200. Pla	ICE Of Disposition	on (Name of ce	Court	Apt. E Gl	en Burnie	, MD 21060				
Baltimore, permit. Pages I an Department of Hea Important: If ited		1 Burial 2 X Cremation 3 Removal from State Crei	matory or other	r place)		May 10, 2012	20c. Location - Co Baltimo					
Salti ermit. Separtm mports		21. Signature of Funeral Service Licensee	22. Nar	ne and Address	s of Facility							
Physician	_	23a. Park Enter the disease or complications that counsed the death of		Ritchi	e Hwy	, P.A. Sev Sev	erna Park <u>erna</u> Park	Funeral Home MD 21146				
/Medical		fature. List only one cause on each line.										
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):										
	101	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated c										
ecuted and transit		d										
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and upfletcy filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	▼ UNPENDED		me, g92	27 5-2	23-12 sm						
5876 rtificat ling phy	clan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth	cy 2 Fetal o	death 3	Ectopic p	reanene.	23d. Date of deli	·				
Box 687 he death certific the attending p	' W	1 Yes 2 No 9 Unknown 9 Unknown		(Specify)	peropic pi	egitaticy	Month	Day Year				
P.O. Es that the c	Phy	Part II. Other significant conditions contributing to death but not result	ting in the unde	erlying cause gi	iven in Part I	23e Did to	hacco use contribute	e to the cause of death?				
S, P.(ed by	Chronic Alcoholism, Gastrointest						Probably 4 V Unknown				
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be in by the funeral director, page 2 should be a siled in by the funeral director.	Completed	l 				24a. Was autop	- 1-1	e autopsy findings available to completion of cause of				
tal Rection: The certificate ector, page		26 Was core extended.				perfor	med? death	h?				
Vital ysician his cert directo	m	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatient 3)thor -	neck only one)						
Ing Ph After t funeral	유	27 Manager of Death	D. Time of Injury				Residence 6 🗸 01	ther: Scene				
Attence r death	Įğ.	2 Accident Investigation			s 2 No							
Divis spital or At hours after d neral Direct	Certification	3 Suicide 6 Could not be determined (Specify)	farm, street, fa	ctory, office bui	ilding, etc.	28f. Location (S or Town, St	treet and Number or ate)	Rural Route Number, City				
To the Hosp within 24 ho To the Fune completely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred :	at the time, date	and place	and due to the cause	a(e) and manner as a					
To the within To the comp	8 [one) 2 Medical Examiner: On the basis of examination and/or and manner stated 29b. Signature and title of certifier	investigation,	in my opinion, o	death occurr	ed at the time, date a	nd place, and due to	tated. the cause(s)				
		The state of continent		29c. License	_		29d. Date signed (M	Month, Day, Year)				
	-	30. Name and address of person who completed cadse of death (tem 23a)		U.C.IVI	0	CME	May 8, 2012					
10		Theodore M. King, Jr., MD. Assistant Medical Exam		W. Baltimo	re Street	, Baltimore, MD	21223					
Sta Registr	te ar	31. Date filed (Month, Day, Year) 2012 32. Fegistrar's Signature	back	1								
			17									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 11. Day 2012 Year Physician/ Mayonth 11:29 A M Rykhus Nancy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick 6858 Buttonwood Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours Dec. 20, 1928 118-22-9232 New York Director 1 M 2 X F 83 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State notified at Director Frederick MD Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral United States 21703 6858 Buttonwood Court items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ò 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Media Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice Bertha Cobb Charles Ewels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113 Brecken Dell Court, Frederick, Maryland 21702 Joe Meisner (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/14/2012 Smithsburg, Maryland Smithsburg Cremators ure of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home MO1612 106 E. Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 autopsy perforr 1 Yes 2 No this certificate Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5X Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 🗆 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature a 29d. Date signed (Month, Day, Year) 2

& Oh

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJJAD A212, MD 80, To

DS83

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 1 - State RegistAMEND#5+12perINF,5/7/12;BMW.MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4/29/2012 CARLOS ANTONIO ROSARIO 22:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Montgomery Rockville 107-40-2951 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Puerto **Director** 107-40-2950
Usual Residence of Decedent 1 □ M 2 □ F 63 1/10/1949 Ciales, Rico 10a. State 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f sl notified MD Montgomery Village Montgomery 1 ☐ Yes 2X No 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ns 23a c cmust b Funeral 20029 SpurHill Drive 20886 TISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 X Yes Z Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Divorced 4 Divorced Completed Hispanic Year or Date 967 - 1972 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other t 4 vr Cardiovascular Technician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ traumatic Juan Rosario Julia Santos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shown and 2 shown a t: If item 27 is Gladys Rosario/wife 20029 Spur Hill Drive, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any injury or Ardent Crematory 5/2/2012 Hanover, MD 21. Signature de l'eral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Acute Physician) liver disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** aastrointestina Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Advanced cirrhosi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hepatitis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, artery disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖭 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical **Division of Vital** Hospital or Attending Physician; funeral director, 26. Place of Death (Check only one) Be Certificate: To 1 Yes 2 No Other: 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 5 68315 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Rockville MO 20850 Wel 9901 Medical Center

Registrar

31. Date filed (Month, Day, Year,

MAY 03 2012

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OSario

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 4:55A Robinson 04 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 51 Director 218-80-4202 1 □ M 2 🗓 F 10/20/1960 DC 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 XYes 2 No Gaithersburg Montgomery MD 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 20877 428 North Summit Ave. #201 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mess Attendant Service Source Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Marie Strickland Curtis Howell, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Husband 428 North Summit Ave. #201 Gaithersburg, MD 20877 Anthony Kenneth Robinson/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Durial 2 Dremation 3 Removal from State Metropolitan Crematory05/12/2012 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lizensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Esophageal Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 in the past 12 months? Month signed by the at Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\overline{\text{Norther}}\) Other (Specify) Hospice 2 □XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04/29/2012 R120698

State Registrar 31. Date filed (Month, Day, Year)

MAY 03

6001 Muncaster Mill Rd. Rockville, MD 20855 Nicole Christenson CRNP 37 Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Mansureh Rashidchi 8:30 am Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Nursing Home Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours onth, Day, Year) | 14 | 1998 546-49-2652 Director 84 Iran Usual Residence of Decedent 10a. State 10b County 10c. City. Town or Location the Maryland notified at 10d. Inside City Limits Director 28a-f Maryland Potomac 1 Yes 2 No Montgomery 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 20854 U.S.A. 1702 Sunrise Drive ral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Black White etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 Divorced Caucasian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) 12 Homemaker Own Home if Health and Mental Hygie item 27 is marked other it other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Robabeh Aslankhani Gholamreza Hajaliakbari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1623 Arrowhead Avenue, Livermore, California 94551 Saman Rashidchi - Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or oth cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory, 05/07/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft. permit. 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee MD 20852 Center. 1040 Rockville Pike. Rockville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine e attending physician and ed for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Dav Year signed by the a Id be detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has t completed filled in by the funeral director, pa e 2 s performed? Yes 2 No 1 Tyes 2 🗆 No 25. Was case referred to medical examiner? **Division of Vital** Be (26. Place of Death (Check only one) é Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

DHMH 17 Rev 7/2009

only one 29b. Signature and title of certifi

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month MAY RANKLIN Physician/ 04-52 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HICOMICO 544136414 RIGIONAL MEDICAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Ars. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 222-18-7936 1**X** M 2 □ F 79 10/28/32 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Berlin Worcester 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 10943 Pitts Rd. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 ₺ No f Yes, Give ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Completed Specify: white 3 Widowed 4 Divorced Year or Dates er than "natur the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing of Health and Mental Hygie If item 27 is marked other r other traumatic event, th marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Ruark Lelia Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Della Ruark / wife 10943 Pitts Rd., Berlin, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 0 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Riverside Cem. 5/5/2012 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer ervice Licenses 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter thus isease, or complications that, aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TICEMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) this certificate has been signed by the arral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEART ONGESTIVE Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 1 Yes 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day,

Division of Vital

100 E. CARROLL ST., SALISBURY, MD

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Pate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Honth Physician/ 52 TM RMA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Assisted Living <u>Annapolis</u> <u> Heart Homes</u> If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Director 216-16-4431 1 🗆 M 2 🗶 F 89 April 1 1923 Maryland Usual Residence of Deceder or 28a-f shov 10a. State 10b. Count 10c. City, Town or Location filed within 72 hours after death with the Maryland 놞 10d. Inside City Limits Director notified 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 23a r Funeral must USA 13214 Club Road items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Force Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Specify. Completed 3 X Widowed 4 Divorced USA Year or Dates. Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event ****. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 0 Bank Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Viola Tucker Harry Basil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 649 Magothy View Drive, Arnold, Maryland 21012 Barry Root – Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park | 5/11/2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) Minnich Funeral Home Signature of Funeral Service License 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ heroscle disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy been signed by the atter should be detached for in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar has page 2 autopsy perform After this certificate 1 Yes 2 🗌 No Yes 2 director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital 25600 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work' 5 Pending within 24 hours after death.

To the Funeral Director: At 2 No Investigation Could not be Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of

Registrar

State

31. Date filed (Mon:

e and address of person who completed cause of death (Item 23a)

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 3 May 8:00 Caro1 A^{M} Sharon Rogers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert 3847 6th Street North Beach 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Days Min 216-40-5946 1 □ M 2 🔏 F Director 10-22-1943 Maryland Usual Residence of Decedent 68 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified 1 ☐ Yes 2 🕅 No North Beach MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3847 6th Street 20714 USA items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic and the statement of 1 Never Married 2 X Married by 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Should be more than and Mental Hygiene.

27 is marked other than "natural marked other than "natural marked other than "natural marked other the Medical Expression of the marked Expression of the marked other than "natural". Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Delicatessan Clerk Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lucille Marv Wood William Alexander Hooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3847 6th Street, North Beach, MD 20732 John Francis Rogers, Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 \square Cremation 3 \square Removal from State 05-08-2012 4 ☐ Donation 5 ☐ Other (Specify) Central Cemetery Barstow, MD 21. Signature f Eyneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. M00715 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Onset and Do Immediate Cause (Final Physician/ an disease or condition non Medical resulting in death) Due to (or as a confequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 X No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Il Director: After the din by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A: completely filled in by the fi 1 Tes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) na Frederick ate 31, Date filed (Month, Day, Year) 32. Registra State MAY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Dorothy Ann Redden 6:04 AM 04 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Wicomico the Salisbur Hospice at Coastal If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min. (Month, Day, Year) 218-12-1532 **Director** 1 □ M 2**X** F 89 01/31/1923 Maryland Usual Residence of Decede ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 X Yes 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Maple Avenue 21660 USA 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or iter or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 XNo Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☐XWidowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Space & Aeronautic Seamstress S. Grad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Lynch Emily Beaumont 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Shorts/daughter 26751 Rigbylot Road Royal Oak, Maryland 21662 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State Ridgely Cemetery Ridgely, Maryland 4 Donation 5 Other (Specify) May 3, 2012 Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South 2nd Street Denton, Maryland 21629 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ RRBROVASCUAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical lor Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for I in the past 12 months? Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be de Be Completed by 2/ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops 1 🗌 Yes 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28c. Injury at work? 1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral Natural N 5 Pending 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d Date signed (Month, Day, Year, 20,58410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month,

1300

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egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 2012 Year Simmons 11 12:20 a.^M William A. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Mt. Airy Kline Hospice House 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 220-26-7380 Usual Residence of Decedent **Director** 81 Maryland 10/18/1930 28a-f shov 10d. Inside City Limits 10c. City, Town or Location must be notified at 10a. State Director 1 Yes X No MD Frederick Frederick 10g. Citizen of What Country? 10e, Street and Number ō Funeral items 23a 6620 Ashford Lane 21702 United states Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72... h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) President Printing Company Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) ပ Elsie Cronise Richard Fessler Simmons Just 1 and 2 sh. Juportant: If item 27 is m'y injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Simmons / wife 6620 Ashford Lane, Frederick, MD 21702 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Smithsburg Crematory 5/12/2012 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licensee Depulu Ku MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final conce - Physician/ disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Siain merastasis temporal Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown isigned by the a did be detached for 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother Specify House မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 5 Pending work 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05-11-2012 DO067691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Ord 21701 Goldste. 01

State Registrar 31. Date filed (Month, Day, Year) MAY 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 3, 2012 6:40 A Medical Joseph Sheleheda 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Prince Frederick County of Death Calvert Memorial Hospital Calvert Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 12-07-1915 1 **X** M 2 □ F Months Hours Min **Director** 169-05-6108 96 PA Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Solomons 5 MD Calvert 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral United States 1205 Back Creek Loop 20688 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates. 1945-46 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance of Dies Steel Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Leona Narbesky Wasyl Sheleheda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11114 Beacon Way, Lusby, Maryland 20657 William D. Sheleheda - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Peter & Paul Ukrainian 5/08/2012 Ambridge, PA Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 56 P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician. (oronar Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for the a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 I signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantionen To the best of my knowledge, death occurred at the time, date and place, and due to the o 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 0234668 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospitel al. Prince 12+1 Mar Kusme 20 31. Date filed (Month, Day, Year) 32. Registr, s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Min. Days Hours 186-34-9664 Director 70 1 M 2 K XF 3/24/1942 PA Usual Residence of Deced show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director be notified 28a-f 1 🗌 Yes 🕱 🛣 No Annapolis MD Anne Arundel 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral "natural", or items 23 870 Chestnut Tree Dr. 21409 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★★No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2XX No Specify Specify. 3 XXVidowed 4 □ Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Hospitality Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Acosta Howard Harding 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 870 Chestnut Tree Dr. Annapolis, MD 21409 Son William Sade 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit, Page 1 Burial 2 Cremation 3 Removal from State 5/5/2012 Glen Burnie, Md 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Live see 22. Name and Address of Facility Hardesty Funeral Home, P.A. 700 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ cirebrishalar accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner EIMMENTS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-transit D MOCY the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 1 Yes 2 No ☐ Yes 2 No the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 ☐ No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year, injury work?
1 Yes 2 No 5 Pending s after death. М Accident Investigation 2 Acciden within 24 hours after dear To the Funeral Director completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar 29b. Signature and title

Date filed

Heather A Parsons

032012

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

MP

Registrar's Signature

DHMH 17 Rev 06-2011

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29d. Date signed (Month, Day,

Maryland

Baltimore

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		Buckinghams Ch		7. Age (In yrs.	last birthday)		amst 1 Year		24 Hrs.	8. Date of Birtl	h	ederic 9. Birthi	place (State or Foreign
Funera Directo		131-03-0229	1□M 2ĂF	9		Months	Days	Hours	Min.	July 3,	1917	Cou	ntry) NY
P		Usual Residence of Decedent				-							
arylar show dat	<u></u>	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2X No
8a-f	Director	MD Frede	rick	Ad	amstow		0 1				10- Citizen	of What Cou	
with th	Dir	10e. Street and Number 3200 Baker Cir	1.			10f. Zip					USA		ntry?
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thoute ad Me mark matic	2	19a. Informant's Name/Relations			19b. Maili	na Address	(Street a			al Route Numbe		wn, State, Zi	p Code)
Md 2 s tth ar 27 is		Deborah Muns				-	,			Frederi			
S 1 ar f Hea item othe		20a. Method of Disposition		1 0	Place of Disposemetery, crea	osition (Nan	ne of			Date		on - City or T	
Page lento nt: if		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		state	rklawn				05/0	03/2012	Rocky	ille.	MD
mit. partm		21. Signature of Funeral Service	Licensee							uffer E			
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Physiciar /Medica Examine	1	23a. Part1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	aused the deat ach line. Late or as a conseq	e ffe					or respiratory ar	rest,		Approximate Interval Between Onset and Death
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ertificate be ex ling physicien ie as the buria	Medicai	IF FEMALE:	d									Date of deliv	
Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physicien and rial director, page 2 should be detached for use as the burial-transit.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	onths?							230.	Pery Day Year		
s that	by P	Part II. Other significant condition	ons contributing to de	eath but not res	sulting in the u	anderlying o	ause give	en in Part I	l,	23e. Did to	obacco use o	contribute to	the cause of death?
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or Attending after death. I Director: After din by the fune	ertification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At h	ome, farm, st	m reet, factor		Yes 2 🗌	1140	28f. Location (: City or Tox		umber or Ru	ral Route Number,
To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifyii (Check only one)	Physician: To the Exeminer: On the ba and mann	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	th occurred nvestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	red at the time,	date and pla	ice, and due	to the cause(s)
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5		30. Name and address of person Vette War	ren MD	e of death (Iter	m 23a) (Type	Print)	thie	C+	. M	yersu:	lle m	0 2	1773
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Louis Prosser Sparks 9:28 PM 2012 Apri 9 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 216-32-0968 76 Yrs 1 XM 2 □ F Oct. 9.1935 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dundalk 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 United States 6604 Maple Avenue Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Yes 2**X** No Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XNo Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Should be filed with h and Mental Hygien 7 is marked other th Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Finley Ross Sparks, Sr. Delma Elizabeth Dawkins traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is a any injury or other traunonce. Mary S. Sparks/Sister-in-law 3605 Fox Run, East New Market, MD 21631 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Centreville Cemetery! May 2012 Centreville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Mid Shore Cremation Center 21. Signature of Funeral Service Licensee Aristens PO Box 1464, Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ spiration disease or condition resulting in death) Medical as a consequence of Examiner vamous Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on Exami and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death by the 9 Unknown Unknown P.O. Part II. <mark>Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ه</u>[Division of Vital Records, 12 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? ate has bage 2 s performed Vas 2 certificate 1 Yes 2 No rector, Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Hospital 24 No Other: ည 6 Other (Specify) We SOV CO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after deau.

To the Funeral Director: After this completely filled in by the funeral d funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Natural work? 1 🔲 Yes 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 2012 20

Registrar

DHMH 17 Rev 06-2011

State

6701

W

32. Registrar's Signature

N. Charles

NOEWST

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

31. Date filed (Month, Day, Year)

DO YAK

HARVES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OOM Stanley A. Smith Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 300 Chicopee St. Garrett Loch Lynn . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Birthpiac Country) MD Days 03/14/1917 1 **№** M 2 🗆 F Months Hours Min 95 **Director** 220-10-8734 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD Loch Lynn Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 **USA** 300 Chicopee St filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Specify. jed 3 Widowed 4 Divorced White the Medical Complet 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repairman 12 other traumatic event, Department of Health and Mental H Important: If item 27 is marked oth any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ramsey Smith Nora Glotfelty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Smith / Son 305 Loch Lynn Street, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
■ Burial 2
☐ Cremation 3
☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/15/2012 Deer Park, MD Deer Park Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) vular Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury mae anding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy page 2 death? 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital Other: မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 5 Pending injury Natural 2 🗆 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one title of certif 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 05 Year 2012 Lena S. Schrock 11:40 A^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 108 Lynndale Road Garrett Oakland 8. Date of Birth (Month, Day, Year) 03/27/1929 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 💢 F Months Hours Country) Director MD 83 215-36-7733 Usual Residence of Decedent 3a or 28a-f show t be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Should be mod
and Mental Hygiene.
7 is marked other than "natural", or items 23s 108 Lynndale Road 21550 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 .No Specify Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 8 Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel U. Yoder Abigail J. Helmuth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Lynndale Road, Oakland, MD 21550 Edward Schrock / Son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/9/2012 Oakland, MD Gortner Amish Cemetery Signature of Funeral Service Lice 22, Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months? Month Dav Year Pregnant at time of death detached Unknown signed by the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 No 3 Probably 4 Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death. **To th**e **Funeral Director:** After this certificate | 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 🗌 Inpatient 2 🗋 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

Registrar

nth, Day, Year

Item 23a) (Type, Print)

Registrar's Signature

Baltimore, Maryland 21215-0036

	Ex	/ledica amine
Division of Vital Records, P.O. Box 68760	ital or Attending Physician: The law requires that the death certificate be executed resetter death	rations occurs. Table for this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial-transit.

	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No.														
		Registrar	- 75:	- (ant)		Ce	tificat	e of E	eath			Reg. No.			_
Physiciar Medic		1. Decedent's Name		Ernes		t Shiffy					2. Date of Dea	Day	2 ₂₀₁	2 7:00 P	M
Examine		4a. Facility Name (if 405 Sunnysi	ide Road	, give street and nui			4b. City,	Town, or	Cocation of Oak	land		4c. County of Death Garrett			
Funeral Director		5. Social Security N 215-36-	8682	6. Sex 1 X,M 2 ☐ F		s, last birthday) 73 Yrs.	If Unde Months	n 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h 8/13/38	9. Bii Co	thplace (State or Foreignatry) WV	gn
ryland -f show ied at	ctor	Usual Residence of 10a. State	10b. County		10c.	City, Town or Lo	cation		0.11					10d. Inside City Limit	
th with the Maryland ms 23a or 28a-f show must be notified at	al Dire	MD 10e. Street and Nun	mber	Garrett			10f, Zip	Code	Oakl	and		10g. Citizen	of What Co	1 ☐ Yes 2 💢 I	VO
death with	Funeral Director	405 Sunnysi		Armed Fo	edent Ever in	U.S. 13.	Was Deced	dent of His	215:	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ame	SA erican Indian,	_
urs after dea ural", or ite	ted by	1 ☐ Never Marr 3 ☐ Widowed	4 Divorced	ried 1 2 Yes If Yes, Gi Year or D	2 □ No ve 10	1961 - 1963 1 ☐ Yes 2 X .No Specify: Specif							Black, Whit	White	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Seco	ecify only higher onday (0-12)	nt's Education est grade completed College (*		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver								•	
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nd 2 sho salth and n 27 is r er traun		19a. Informant's Na Carol Shiffy		nip (Type, Print)			-				Route Number	r, City or Towi	n, State, Zi	p Code)	
Page 1 arent of Hent of Hent of Herrory or other		1 🗌 Burial 2	20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State 20b. Plac						position (Name of ematory or other place) Ex Cremation Service 5/7/2012					Town, State	
permit. P Departin Importa any inju		21. Signature of Fur			A	22	. Name ar	d Addres	s of Facility	,	P 4 21 No			Oakland, MD 2155	
		shock, or hear	rt failure. List o	complications that									Sireei,	Approximate Interval Between	0
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)		a. Due to	(or as a conse	Smo	lef-	+ lu	ng					3 years	
Examiner	Jer	Sequentially list conif any, leading to im		b. Due to	or as a conse	cale	mie	2						Gmo	
and I-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying iinjury s	c. Due to	1 0 x X	ewince of):	/_					_		6mo	
ate be executed physician and the burial-transit	dical			d			-								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No		Birth 2 D Fi gnant at time o	etal death 3	Ectopic (ý				Date of de Month	livery Day Year	
igned by	by Ph	Part II. Other signif	ficant condition	ons contributing to c	death but not r	resulting in the u	nderlying	cause give	en in Part I		,			the cause of death?	
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ificate ha		25. Was case referre	ed to medical					26 Pla	ce of Deat	h (Check	1 Yes	rmed? 2 🏳 No	death?	_/	
ysicia ils cert direct	To Be	examiner?	∠ No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 🗆 D0	Othe	r:		ne 5 Resid	lence 6 \square C	ther (Spec	ify)	_
eath. or: After th		27. Manner of Death 1 Natural 2 Accident	5 Pendin Investig	gation	of injury th, Day, Year)	28b. Time of injury	M 2	8c. Injury work? 1 🗆 ۱	at ? Yes 2□		8d. Describe h	ow injury occ	urred		
rs after dall Directed in by t		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could i determ	inod 28e. Place	e of Injury - At ing, etc. (Spec								ation (Street and Number or Rural Route Number, or Town, State)		
ne Hospi in 24 hou ne Funer pleted fill	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as only one)										due to the	cause(s) and manner sta	ated.	
		29b. Signature and t	title of certifier	G La	le.	M	290	. License	number	7		29d. Date sig			
+	VA	30. Name and adde	ess of person v	who completed caus	se of death (Ite	em 23a) (Type, F	rint)	off	hins	2112	w (C	akla	nd	2012 MJ 2155	_ D
State Registra	-	31. Date filed (Month	h, Day, Year) - 7 20	12 Jane	legistrar's Sig	nature	مل	-11		, y - (x C	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:25 PM Mary Alice Sanford 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Prince George's Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months 131-14-3333 Director 1 □ M 2 🖾 F 90 September 9, 1921 Pennsylvania Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City, Town or Location Director Maryland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4302 74th Avenue 20784 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Examiner Black, White, etc. ō þ 1 Never Married 2 Married 2 X No Yes filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: nand Mental Hygiene.
7 is marked other than "natural", raumatic event, the Medical Exa White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Raymond Gutoski Martha Casper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Mary Ann Garrett / Daughter 14700 Harold Road, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/8/2012 Brentwood, Maryland Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying the attending physician and shed for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🖁 No Day Month Year Pregnant at time of death Unknown þ s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Division of Vital Records, Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 1 ☐ Yes 2 ☐ No Director; After this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 X No Other: 1 🗌 Yes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending death. 1 Yes 2 No М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Hospital Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month. Dav. Year) who completed car se of death (Item 23a) (Type, Print) 3001 HOSPITAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1013 AM SHOEMAKER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MD Maryland Med Baltimore University 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 2 🗷 No ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 🗌 Widowed 4 🗆 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Non NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ SHOEMAKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHOP 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 Department of Important: If it any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Signature of Funeral Santas Consee CLSU-COR Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ S drop Medical resulting in death) Examiner 13 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trar To the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Year signed by the at d be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 →No 3 ☐ Probably 4 ☐ Unknown cate has been significant category can be seen significant category. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No illed in by the f Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a

To the Funeral I

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2012 LILLIAN ELLIOTT TAYLOR 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Denton Homestead Manor Social Security Number If Under 1 Year If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, March 7 1 M 2 X 98 056-05-8541 Director 1914 Pennsylvania Usual Residence of Deceden "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State filed within 72 hours after death with the Maryland Director Queen Anne's 1 Yes 2 X No Chestertown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21620 U.S.A. 116 Hickory Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 XWidowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant. If item 27 is marked other than 'ury or other traumatic event, the Meury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Theodore Augustus Yunckert Lillian Shannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Peters (daughter) 116 Hickory Lane Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial → 🖾 Cremation 3 ☐ Removal from State Kent Cremation Service 5/14/12 Smyrna, DE. 4 Donation 5 Other (Specify) 21. Signifur of Four al Service L 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 118 West Cross Galena. 23a. Rart : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart railure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or contion resulting in death) Onset and Death a Cerebral Vascular accident Priysician Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed has certificate Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 W Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one re and title of certifier 29b. Signa WD 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hoptank RZ Presta MD21655 3683 (melinda 32. Registraris Signature 31. Date filed (Month, Day, Year) **MAY 1** 3 2012 State

Registrar

1-1. De

ADEES JABER
31. Date filed (Month, Day, Year)
MAY 03 2012

Medical Certificate: To Be Completed by Physician/Medical Examiner

Be Completed by Funeral Director

မ

Physician/ Medical

Examiner

Funeral

Director

	Please 1	Type or Pri						-			e.	
For State Registrar		State of Mi	aryland /			e of Dea			Reg. N	20	12	15982
1. Decedent's Name	e (First, Middle, Last)							2. Date of De		You You	3. Ti	me of Death
PATRICI.	A ANN THOM	IPSON						APRIL	28 ً	2012 ^{ea}	6:	12 P M
	f not institution, give st				,	Town, or Loca				c. County of D		
5. Social Security N	NDEL MEDICA		e (In yrs. last bir	hdav)		NAPOLIS er 1 Year If U	Inder 24 Hrs.	☐ 8. Date of Bir				tate or Foreign
228-98-72 Usual Residence of	277	M 2 X) F	59	Yrs.	Months	Days Ho	urs Min.	02/04/	y, Year,		Country) NNSYLV	
10a. State	10b. County		10c. City, Tow	n or Loc	ation							ide City Limits
MD	ANNE ARUNI	DEL	ANNA	POL	IS						1 🔀	Yes 2 □ No
10e. Street and Nur 304 HIL	mber LTOP LANE	UNIT B			10f. Zi	21403			-	Citizen of What TED ST.	-	
11. Marital Status	11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-											
Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No If Yes, specify Cuban, Mexican, Puèrto Rican, etc.) 3 Widowed 4 Divorced Year or Dates. Armed Forces? 1 Yes 2 X No Specify: WHI												
(Spe	15. Decedent's Edu		16a			al Occupation	most of work	kina	16b.	Kind of Busine	ess Industry	
Elementary/Sec		College (1-4 or 5		life. DO		e retired)	most or worr	ang	D	ISABLED	•	
17. Father's Name (i	(First, Middle, Last) EDWARD THC	MPSON						ne (First, Middle, MA HOSE	Maide	n Surname)		
19a. Informant's Na	ame/Relationship (Type	e, Print)	198	. Mailin	g Addres	s (Street and N	umber or Rur	ral Route Numbe	er, City	or Town, State,	Zip Code)	
ROBERT EF	RNEST THOM	PSON/BROT	HER 30)4 H	ILLT	OP LANE	UNIT	B ANNAP	OLI	S, MD 2	21403	
1 🗌 Burial 2	20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 04/20/2012 CTEVENSVILLE MD											
	ineral Service nicensee	le frem	I GE	NTEF 22 HE 81	Namea	nd Address of BEIN &	Facility T.A.S	TING TR CREMAT ANNAPOLI	TRII	TES BY	FELLO	WS
	onditions, namediate brilging linjury s	Due to (or as a Due to (or a) Due to (a consequence	of):	and	non disense ciency	ch as cardiac	or respiratory ar	rest,		Interv	eximate al Between at and Death
	d	113 000	7777	1100	~~~~						0000	<i>y</i> -
IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 € 9 ☐ Unknown	months?	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal deat		Ectopic Other (s					23d. Date of Month	delivery Day	Year
^	ficant conditions conf	-	ut not resulting	in the u	nderlying	cause given in	Part I.			use contribute		e of death?
Demb	itu ulcer	_						24a. Was auto perfo		prior	to completio	dings available on of cause of
25. Was case referre	and to modical					00 PI	(D . II . (O)	1 🗆 Yes	2			lo
examiner?	/	ospital:	ent 2 🗆 ER/O	ıtnation	+ 3 \square r	Other:	f Death (Chec	ome 5 🗆 Resi	dence	6 Other /C	neciful	
27. Manner of Deatl 1 Natural 2 Accident	h 5 Pending Investigation	28a. Date of inju (Month, Day	ry 28b.	Time of injury		28c. Injury at work?		28d. Describe			<i>becity)</i>	
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injubuilding, etc		ırm, stre				28f. Location (S City or Tov			Rural Route	Number,
(Check 2 only one) 3	3 Certifying Nurse	er: On the basis of e	kamination and/	or invest	igation, in	my opinion, de	ath occurred a	at the time, date a	and pla	ce, and due to t	he cause(s) a	nd manner stated.
29b. Signature and		AL HOSE	ITALIS	T		c. License num				Date signed (Mc $4/28$)	1	
30. Name and addr	ress of person who cor				_							

ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS, MD 21401

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2012 Maria Elba Villalta ам May 8:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2000 Ravenswood Street Hyattsville P.G. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Country Director 213-15-8827 1 □ M 2 🖾 F 85 Aug. 16, 1926 Salvador Usual Residence of Deceden r then "natural", or items 23e or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. Hyattsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2000 Ravenswood Street 20782 El Salvador Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 1. Marital Status 14 Race - American Indian Armed Forces Black White etc. 1 and 2 should be filed within 72 hours after d of Health end Mental Hygiene.

of Health end Mental Hygiene.

of the Trainmatic event, the Medical Evenin other traumatic event, the Medical Evenin þ 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 Specify White 1 🌣 Yes 2 🗆 No Specify: Salvadorian 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Juan Francisco Chacon Silveria de Carmen Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moises Villalta/Son 3211 Sacred Heart Way, NW, Washington, DC 20010 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD <u>Gate of Heaven Cemetery</u> 2012 21. Signatu e of Funera Service .22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Diabetes Mellitus Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) sician and burial transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and [Completely filled in by the funeral director, page 2 should be detached for use as the burial-gransit Congestive Heart Failure that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Day Pregnant at time of death 5 Other (specify) Month Year g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 K Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, pege 2 s autopsy 1 Yes 2 No Yes 2X XNO Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🖾 No <u>|</u>2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No М ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date/signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

5711 Sarvis Avenue, #302, Riverdale, MD

20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eduardo Flores, MD

MAY 03

31. Date filed (Month, Day, Year)

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			For State Registrar		State of	r Mary		artment of <i>rtificate of</i>		and IVI	entai Hy	giene Reg. No.	2013	15981	
	Physicia	m/	Decedent's Name (Firs	t, Middle, La	,						2. Date of De	ath	∠ U I ℓ	3. Time of Death	
a the	Medic Examin	al	4a. Facility Name (if not in			JINOVO ber)	rtaya	4b. City, Town,	or Location	of Death	May 02 2012 020 4c. County of Death				
angle'	Exami		Subw	rban H	ospital				Beth	esda		40. (Montgomery		
	Funeral Director		5. Social Security Number 215-35-888 Usual Residence of Dec	84	Sex □ M 2 汉 F		rs. last birthday) 88 Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Bir (Month, Da 01/1	th ly, Year) 8 / 192			
	yland -f show ed at	ctor	10a. State 10b.	County		10c	. City, Town or Lo			r i hii i				10d. Inside City Limits	
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	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland darfment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.	Funeral Director		21 Mid	line Cou	vrt		20878						u.s.A.	
920		by	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 💢 [12. Was Deced Armed For 1 Yes If Yes, Give Year or Da	ces? 2 X No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🕱 N			ify Yes or No- lican, etc.)		4. Race - Ame Black, White Specify:		
15-0	72 hour	Completed		Decedent's E nly highest gi	ducation rade com <i>pleted)</i>		(Give	dent's Usual Occ kind of work don	e during mos	t of workin	g	16b. Kir	b. Kind of Business/Industry		
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Maryland	hould band Means s mark	1 17	19a. Informant's Name/R		Varnova Type, Print)	Ly	19b. Mail	ng Address (Stree	et and Numb	er or Rural	_			Code)	
Z,	and 2 s Health a em 27 i her tra		Yakov Vari		- Son	La		idline (Court,						
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Baltimore,	permit. Page Department Important: I any injury o once.		Judean Mem. Gardens 05/03/2012 Olney, Marylo 21. Signature Full cral pervice Iran Word Word											Home, Inc.	
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicis. To the theretor After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medica	23b. Was decedent pregr in the past 12 month 1 Yes 2 X No 9 Unknown	ns?	23c. If yes, outo 1 Live E 4 Pregr 9 Unkn	Birth 2 🗌 ant at time	Fetal death 3	☐ Ectopic pregna☐ Other (specify)	ncy			2	3d. Date of de Month	livery Day Year	
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Division of Vital Records,	The law requate has bee page 2 sho	Completed	De	mentia							24a. Was auto perfe 1 \(\sum \text{Yes}\)		prior to death?	topsy findings available completion of cause of	
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ivisio	l or Atten after deat Director: I in by the	Certificate:	2 Accident 3 Suicide 6 4 Homicide	Investigation Could not Indexemble determined	28e. Place	of Injury - A g, etc. (Sp		reet, factory, office		-	8f. Location (City or Tox		Number or Ru	ral Route Number,	
	Hospita 24 hours Funeral letely filled	Medical	(Check 2 I M	ledical Exam	niner: On the basi	s of examin	ation and/or inves	occurred at the ti stigation, in my opi e, death occurred a	nion, death o	ccurred at t	he time, date :	and place,	and due to the	cause(s) and manner stated	
	Vithir To th	2	29b. Signature and title	f certifier	1.17			1	se number			29d. Date	signed (Monti	n, Day, Year)	
•	*		30. Name and address of		statu		Item 23a) /Time	Print\	D599	80		Ma	y 02, 2	012	
			Sandra M.	Delisa	tathis,	M.D.,	8600 O	ld Georg	etown	Road,	Bethe	esda,	Marylo	ind 20814	
	Sta Registr		 Date filed (Month, Day 	y Year) 3 201	72. Re	egistrar's Si	gnature face	W.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Registrar

1 - State Amend Registrar

27 per me,g927,05/23/2012dhb
Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 422 M Gennaro C. Vezza 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours **Director** 133-14-7887 M 2 F 86 2/1/1926 NY 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director the Medical Examiner must be notified MD Worcester Ocean Pines 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 9 Funeral or items 23a 21811 3 Pelican Way USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 'natural", If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) Steam SHip Business Travel and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Domenic Vezza Mary Cavaliere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Therese Vezza / wife Pelican Way, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date t o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State First State Crem. 5/4/2012 | Millsboro, DE 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 2 mla 23a. Part 1. Enter the disease, of complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2 On et and Death Immediate Cause (Final 'ulmonary Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) signed by the attending d be detached for use as IE FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Complications 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of 1 Natural 2 Acc 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending (Month, Day, Yea injury ပြုပ် work?
1 Yes 2 No 5 Pending tall Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or prestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my providing death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge 29c. License number 1+50497 29b. Signature a<u>nd titl</u>e of certifier D006390 Y 30. Name and ad and address of person who completed cause of death (Item 23a) (Type, Print) Healthway Drive, Berlin MD 21811 9733 Registrar's Signature 31. Date filed (Month, Day, State Jarks MAY 0 4 2012 Registrar

2012

DOD

2111936

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2002 Velma Elizabeth Weller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death **Examiner** Washing Hancock 482 Orchard Ridge Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours 218-34-3476 1 □ M 2 🗓 F Director 74 Yrs. 10/16/1937 MD Usual Residence of Deceder or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2X No MD Washington Hancock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be r Funeral 21750 USA 14821 Orchard Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner: Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Elva Hull Daniel McCormick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14827 Orchard Ridge Road Hancock, MD 21750 Tracy Weller/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Orchard Ridge Cemetery05/08/2012 Hancock, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ignature of Functal Sex 141 West Main Street 0 MO0260 Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Physician/ Lears disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediat cause. Enter Underlying Due to lor as a consequence of Examine law equires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death ed by the a detached f 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 3 X Probably 4 ☐ Unknown 2 🗌 No plnous Completed Myocardial Inferction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate in managed in by the funeral director, pag. 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d Describe how injury occurred 1 Natural Certificate: 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

State

29a. Certifier

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year) **NAY 1** 8 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Spancer

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R115203

29d. Date signed (Month, Day, Year)

747 Northern Avenue Hagershown MD

2012

29c. License number

12-03363

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ilicox Physicia		State of Maryland / Department of I									
al Exami		Mark WILC()X 4a. Facility Name (if not institution, give street and number) 4b	Month Day Year 0915 hrs City, Town, or Location of Death 4c. County of Death								
- uneral Director		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Montgomery Mon								
wny		548-53-0582 1 X M 2 F 48 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits								
penim. 1. 1825 s 1 and 2. Stood to Chief within 2. Itous arts used with the Madyfallu Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show. Injury or other traumatic event, the Medical Examiner must be notified at once.	Director		r Spring 1 ☐ Yes 2 ☒ No Of. Zip Code 10g. Citizen of What Country? 20902 United States								
", or items 23a	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. If Yes 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Sive Year	Decedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White								
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Ith and Me n 27 is ma	٩	5000	ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
tment of Heartast If Item		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	pace) Danon Cemetery 05/04/12 Iselin, NJ								
Sician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the	Carroll St., NW, Washington, DC 20012 mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval								
ledical aminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease or condition resulting in death) Due to (or as a consequence of):	Se Between Onset and Death								
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulti									
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within 24 hours after To the Fuoeral Dire completely filled in b	Medical										
4	¥	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 2, 2012								
	ate	Loo de listado disputado	. Baltimore Street, Baltimore, MD 21223								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Time of Dea Physician/ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** or Location of Death 4c. County of Death 051 ACTIMORE 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year)

July 13, 1973 Months Days Hours **Director** 219-15-4378 1 ☐ M 2 🐪 F 37 Washington, D.C with the Maryland ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? Funeral 327 South Locust Street 21740 U.S.A. be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S. 14. Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) f Health and Mental Hygier item 27 is marked other t other traumatic event, <u>th</u> <u>Administrative Assistant</u> Mechanical Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Wells Donna Kretzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle D. Waugh / Friend 12422 Walnut Pt. West, Hagerstown, Maryland 21740 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 💆 Date Department of Important: If is any injury or or 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory 5/12/2012 5 Other (Specify) 4 Donation Smithsburg, Maryland of Funeral Ser ice Licen Signatu 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Deditor Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregpant 23d. Date of delivery in the past 12 month 3 Ectopic pregnancy
5 Other (specify) ____ Month Pregnant at time of death Day be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No Yes 2 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No ည 1 Yes 1 Ampatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No 1 Natural 5 Pending injury after death. filled in by the Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 🚅 🇲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. icense number 2012

State Registrar 5

34

gistrar's Signature

10515

of person who completed cause of death (Item 23a) (Type, Print)

X

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				•	partment of Health a	and Mental Hyg	jiene			
	_		1 - State Registrar	C	Reg. No. 2012 15989					
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Marily .	Examir	ner	4a. Facility Name (if not institution, give street and n	,	4b. City, Town, or Location of		4c. County of Death			
X			Meritus Medical Cent 5. Social Security Number 6. Sex		Hagerstow		Washington			
	Funeral Director		218-38-0936 Usual Residence of Decedent	7. Age (In yrs. last birthda) 71 Yrs.	Months Days Hours	8. Date of Birth (Month, Day, Aug. 1,	Day, Year) Country)			
	and show 1 at	٥	10a. State 10b. County	10c. City, Town or	ocation			10d. Inside City Limits		
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	a or be no	<u></u>	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ıntry?		
	th wit ms 23 must	Funeral	1541 Crestview Road		21740		USA			
21215-0036	e filed within 72 hours after death with the Maryland that hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	Armed	s 2 🔀 No Give	8. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican 1 Yes 2 No Specify:	in? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Amer Black, White Specify:			
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	and 2 s Health tem 27		Roger Kisiel - brother). Box 422, New	Albany, Ohi	io 43054			
Baltimore,	0		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal fro		ematory or other place)		20c. Location - City or 1			
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Ba	permit. Departr Imports any inji		21. Signal Service Licensee		22. Name and Address of Facility	TITINITOIL I	UNERAL HOME			
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P.O.	that the	y Pł	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?		
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	l Certificate:		ce of Injury - At home, farm, siding, etc. (Specify)	treet, factory, office	l Route Number,				
_	Hospi 4 hour unera ely fill.	Medical	29a. Certifier 1 Certifying Physician: To the Check 2 Medical Examiner: On the base	best of my knowledge, death	occurred at the time, date and p	place, and due to the caus	se(s) and manner as sta	ted.		
	the I thin 2 the F mplet	Me	only (ne) 3 L Certifying Nurse Practition	er: To the best of my knowles of	e, death occurred at the time, date	and place, and due to the	cause(s) and manner as	stated.		
B	6 ₹ ₹ 8		29b. Signartine and title of certifier		29c. License number	037	9d. Date signed (Mo#th, MAY 7 K	Day, Year), 2012		
W	-16		30. Name and address of person who completed sau	use of death (Item 23a) (Type,	Print) 124 E Qui	betan.	81416	MDZ174		
	Stat Registra	e	31. Date filed (Month Pax Year) 8 2012 32.	Registrar's Signature	how					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth SWORT 0 11:12 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Wostina Confe/ Medicol HASOSOWN Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** Min. 219-05-9963 **Director** 1 🖾 M 2 🗆 F 91 Jan. 15,1921 Pennsylvania Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 20526 Trovinger Mill Road 21742 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) pipe organ mfg. foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Paul William Wiles Marie Bartle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5758 Anchor Hill Drive, Sylvania, Ohio 43560 Kenneth M. Wiles - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20c. Location - City or Town, State $\overset{\text{Date}}{9}$, 2012 1 X Burial 2 Cremation 3 Removal from State May Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fyneral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? o Month 5 Other (specify) Day Year Pregnant at time of death 2 1 No 9 Unknown Linknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy performed certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After 1 Natural 5 Pending iniury Accident Investigation Director: Suicide 6 Could not be by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Jan 1

Registrar
DHMH 17 Rev 06-2011

State

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completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 15991 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 APR'IL GREGORY JAY WOLF 8:22 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Country) Director 219-68-9581 1 🕅 M 2 🗆 F 53 NOV. 24. 1958 MARYLAND Usual Residence of Deceden 28a-f show 10a. State 10b. County notified at 10c, City, Town or Location 10d. Inside City Limits Director MD FREDERICK WALKERSVILLE 1. X Yes 2 □ No 10e Street and Number ō 10f. Zip Code ems 23a or 10g. Citizen of What Country? Funeral 6 FULTON AVE 21793 UNITED STATES items ? hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iter edical Examiner 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed WHITE the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) MASTER BARBER BARBER SHOP should be filed with and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ൧ JAMES W. WOLF LORETTA A. MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health s item 27 i JASON L. WOLF/ SON 5415 UNIT A RICKELL RD. TANEYTOWN, MD 21787 or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY 05/05/2012 SMITHSBURG, MARYLAND 22. Name and Address of Facility KEENEY & BASFORD FUNERAL HOME 21. Signature of Funeral Service Licenses M01646 EAST CHURCH STREET. FREDERICK 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician. neumococca bactere mia disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner nen moni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine HIVand that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ☐ Unknown the 9 Unknown by signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy perform death? Hospital or Attending Physician: The Yes 2 Yes 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury death. Accident 1 Yes 2 No Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

400 W 7TH STREET, FREDERICK, MD 21701

Registrar's Signature

ABLANA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYUNG NAM
31. Date filed (Month, Day)

D35106

2012

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		State Registrar	Cen	tificate of D	eath		Reg. No.	012	1599
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Medi	ical	Naomi G. Waynant 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		20 , 201 4c. County		9:21p ···
Exami	ner	Emeritus Senior Living			inster	LII		rol1	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last to	birthday)	If Under 1 Year	If Under 24 Hrs		1	9. Birthp	lace (State or Foreign
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he Ma or 28		Maryland Frederick Sabi	LILAS	10f. Zip Code			10g. Citizen of	What Count	try?
with t	eral	6341 Browns Quarry Road			21780		Unite	d Sta	tes
21215-0036 within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	Vas Decedent of His Yes, specify Cuba	spanic Origin? (S	Specify Yes or No- to Rican, etc.)		ce - America	
36 after of ", or is amin		1 Never Married 2 Married 1 Yes 2 No		Yes 2 No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specify	7	
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id 21215-0036 led within 72 hours after Hygiene. other than "natural", o		Elementary/Secondary (0-12) College (1-4 or 5+)	Sc	hool Tea	cher		Publi	lc Sch	ools
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and Heal				Limerick sition (Name of	1	Date	20c. Location		
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Baltimore, permit. Page 1 and Department of Her Important: If item any injury or othe once.		4 Donation 5 Other (Specify) 21. Signatury if Fungral Sen Colling Specific	1aven	Name and Address	s of Facility	.S			
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Physician Medica		23a. Part 1. Enter the disease, or completations that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	ry	r the mode of dyin	such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
Examine		Sequentially list out the sifany, leading to immediate cause. Enter Underlying	ce of):					- 6	
60 te be executed nysician and he burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C	ce of):						
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 624 hours after death. Funeral Director. After this certificate has been signed by the attending physicial attention by the funeral director, page 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yoo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 🗌	Ectopic pregnanc Other (specify)	у			ate of delive	ery Day Year
S, P.O. Bc res that the dea signed by the a d be detached i		Part II. Other significant conditions contributing to death by not resulting	nd in the ur	nderlying cause giv	ven in Part I.				e cause of death?
Records, The law requires sate has been sig	Completed by	Congestive hea	nt.	faile	ure	24a. Was a autop		Were autop prior to cor death?	osy findings available inpletion of cause of
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sion of	icat	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	injury	M 1 □	? Yes 2□No				
Division tall or Attendir s after death.	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
Divis To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge only one) 3 Certifying Nurse Practitioner: To the best of my knowledge only one) 1 Certifying Nurse Practitioner: To the best of my knowledge only one) 1 Certifying Nurse Practitioner: To the best of my knowledge only one) 1 Certifying Nurse Practitioner: To the best of my knowledge only one) 1 Certifying Nurse Practitioner: To the best of my knowledge on the best of my knowledge	nd/or invest	igation, in my opinio	on, death occurre	d at the time, date a	nd place, and di	ue to the cau	use(s) and manner state
Vith To th	-	29b. Signature and title of certifier		29c. License	e number		29d. Date signe	ed (Month), L	Day, Year)
		Mewiteo, D.O.		HOL	9538	45 1	1120	0/2	012
10		30. Name and address of person who complete cause of death (Item 23	ia) (Type, P	Print) K	ELTO	SUN,	105,	212	787
St	ate	31. Date filed (Month (A) (Men) 2 2012 32. Registrar's Signature	1 1	miles					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:13 am reda Warnick 05 13 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Grantsville 1551 Maynardier Ridge Road If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🕱 F 572171925 Bittinger 86 Director 215-20-5683 Usual Residence of Decedent i Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNO MD Montgomery <u>Laytonsville</u> 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20882 4911 Sundown Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 😾 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Administration Administrator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever 2 be Fazenbaker Marie permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. Wilt Bessie Oscar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4919 Sundown RD. Laytonsville, MD 20882 Warnick/Son Walter L. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bittinger Cemetery5/12/2012 Bittinger, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final tailure Physician/ RENAL Acute 465 disease or condition Medical resulting in death) premania **Examiner** 2 WKs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical MEU. Ta Division of Vital Records, P.O. Box 68760 as 1 been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 No Hospital Other: 4
Nursing Home 5 Residence 6
Other (Specify) ည 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.
Funeral Director: After eted filled in by the funer injury work? 1 ☐ Yes 2 ☐ No 1 ANatural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only on 29b. Signatu 30035 who completed cause of death (Item 23a) (Type, Print) 1627 MEMORIAL DR OAKLAND MD 2/550

Registrar DHMH 17 Rev 7/2009

State

BANDI 31. Date filed (Month, Day, Ye ichter MIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1716 Girolamo Zimini Jr. MAY 0/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5610 Fargo Avenue Oxon Hill Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 577-96-1885 **Director** 1 X M 2 🗆 F Yrs. 47 05/13/1964 Washington, DC Usual Residence of Decedent fshow 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 XXVo Maryland| Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be 23a Funeral 5610 Fargo Avenue 20745 USA items and 2 should be filed within 72 hours after death Health and Mental Hunians 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian Armed Forces?

1 Yes 2 No item 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. marked other than Elementary/Secondary (0-12) 12th College (1-4 or 5+) Terrazo Grinder Stone Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Girolamo Zimini Agata Monteforte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Nancy Zimini / Sister 7017 Bruin Court Manassas, Virginia Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven permit. Page 1 1 Burial 2 Cremation 3 Removal from State 05/04/2012 4 □ Donation XX Other (Specify) Entombrent Silver Spring, MD E neral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Wound To Head Physician/ 6 unshot Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Property of the action of the action of the action of the attending physicial prector. After this certificate has been signed by the attending physicial. P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year 1 ☐ Yes ∠ L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year)

128b. Iao of Injury - At home, farm, street, factory, office building, etc. (Specify) 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred S 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Through Mou Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined Lone Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

State

Name and address of person who comple

MAY 0 3 2012

ed cause of death (Item 23a) (Type, Print)

7 2 3 0 0 1 0 5 0 1

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thomas Louis Andes Medical May 3:50a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5336 Wendy Road Eldersburg Carrol1 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 25 1941 9. Birthplace (State or Foreign 213-36-3238 **Director** 1 X M 2 □ F 71 NJ Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Eldersburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5336 Wendy Road 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 X Widowed 4 Divorced Specify: white Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) plumber plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျ Frank F. Andes Sr. Yolanda Christina Maria Sciascio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i Mrs. Karen Vinci (daughter) 2332 Hidden Brook Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If ite
any injury or otl Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-21-12 Sykesville, MD Lake View Memorial 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel & Parge Hargh & P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ netrastrati Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsv performed? Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending (Month, Day, Year) 1 Yes 2 No Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Cactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 30. Name and address of person vin completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Towson, MD 21204

7501 Osler Drive

affer

Yousut

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mary	land / Departme		Mental Hy	/giene	0 15000
			Registrar 1. Decedent's Name (First, Middle,	Last)	Certificat	te of Death	2. Date of D	Reg. No. 20	2 15996
	Physicia Media		JOHN	Ernest	Andre	WS	Month MA		3. Time of Death 7 - 45 0 M
and the same	Examir		4a. Facility Name (if not institution,		4b. City	, Town, or Location of Deat		4c. County of Dea	th
40.00	Funeral	-	5. Social Security Number	6. Sex 7. Age (In)	Vrs. last birthday) If Under	WINDSOR er 1 Year If Under 24 Hrs	8. Date of Bi		thplace (State or Foreign
В	Director		489-44-2203	1 № M 2 □ F	Months Yrs.		(Month, D	ay, Year) Co	untry)
	land show dat	្រ	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Location		12-7	-1940 1	10d. Inside City Limits
	Maryla 28a-f s otified	rect	Maryland BAC	TIMORE	WIN	dsor Mi	11		1 🗆 Yes 2 🔀 No
	permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	xworth Ct		21244		10g. Citizen of What Co	
	death v	Fune	11. Mantal Status	12. Was Decedent Ever in	n U.S. 13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puert	pecify Yes or No	14. Race - Ame	rican Indian,
36	after or samir	d by	1 ☐ Never Married 2 K Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 2 No If Yes, Give		2 No Specify:	o ricali, etc.)	Black, Whit	e, etc.
2-00	72 hours after n "natural", or ledical Exami	olete	15. Deceden (Specify only highes		16a. Decedent's Usu			16b. Kind of Business	/Industry
21215-0036	within 72 giene. er than ' the Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT us	6.4	rking	USA	ID
	iled will Hygie other	Be	17. Father's Name (First, Middle, La			18. Mother's Nar	me (First, Middle	, Maiden Surname)	
Maryland	uld be fil Mental narked o	မ	Theodo		Andrews	B/A	mch.	e CA	rty
Mar	2 shouth and the strain traum	П	19a. Informant's Name/Relationsh	p (Type, Print)		S (Street and Number or Ru	iral Route Numb	1 1	
re,	of Health of Health fitem 27		20a. Method of Disposition	20	b. Place of Disposition (Na		Date	20c. Location - City or	Mil HD 21244 Town, State
Baltimore	, Page tment tant: If jury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State pecify)	URST Arw		2-2012	Odento	N, MD
Ball	permit, Pag Department Important: any injury conce,		21. Signature of Juneral Service Li	censee	22. Name a	1 -	OSEPK	NZANN,	NO JEFH.
		- 12	23a. Part T. Epter the disease, or o	complications that caused the	death. Do not enter the mod	5. Con/c/ le of dying, such as cardiac		rrest,	Hel Z/224 Approximate
	trysician/		shock, of meart failure. List or Immediate Cause (Final disease or continon	lly one cause on each line.	LASTOMA	MULTIFO	RME		Interval Between Onstitland Death
W.	Medical Examiner		resulting in death)	Due to (or as a con	sequence of):				J.2
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con-	sequence of):				
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con:	paguanga off				-
09	ite be executed hysician and the burial-transit	dical E	resulting in death) Last	bue to for as a con-	sequence on.				
9289	tificate ng phy as the	Medi	IF FEMALE:	_ u					
Box 6	eath certificat attending phy I for use as th	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time	Fetal death 3 🔲 Ectopic			23d. Date of de Month	livery Day Year
). B	that the dea ned by the a e detached i	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	or death 5 🗆 Other (s)	эесну)		, world	Day real
, P.O.	(0 50 0	ρ	Part II. Other significant condition	s contributing to death but not	t resulting in the underlying	cause given in Part I.	i	obacco use contribute to	
space	requires been sig should b	eted						Yes 2 KNo 3 P	
of Vital Records,	he law te has age 2	Completed						psy prior to prmed? death?	topsy findings available completion of cause of
E	ysician: The lav s certificate has director, page 2	Be C	25. Was case referred to medical examiner?			26. Place of Death (Chec		2 XNo 1 ☐ Yes	3 2 □ No
Į Vi	Physi r this c eral dire	은	1 ☐ Yes 2 📈 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of injury	ER/Outpatient 3 D	OA Other: 4 Nursing H		dence 6 Other (Spec	ify)
o uo	ttending F death. stor: After y the funer	icate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year		work? 1 \(\superstack \text{Yes} 2 \superstack \text{No}	26d. Describe	now injury occurred	
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		t home, farm, street, factor	, office	28f. Location (City or Tox	Street and Number or Rui vn, State)	ral Route Number,
	spital		29a. Certifier 1 Certifying I	Physician: To the best of my kr	nowledge, death occurred a	t the time, date and place,	and due to the c	ause(s) and manner as st	ated
	the Ho nin 24 i the Fu npletel	Medical	(Check 2 Medical Exonly one) 3 Certifying I	aminer: On the basis of examinations of examination of the best states	ation and/or investigation, in	my opinion, death occurred a	at the time, date a	and place, and due to the	cause(s) and manner stated
	To COL		29b. Signature and title of certifier	00.10		License number		29d. Date signed (Month	
			30. Name and address of person w	no completed cause of death (tem 23a) (Type, Print)	UTTURS		03/2/12	212
		Ü	Clare Ferriano	1550 DELEM	Item 23a) (Type, Print) US ST, DAVID On of three	KOCH BUDG,	SUITE !	M-16, Bulto	MD 2/287
	Stat Registra	e	31. Date filed (Month, Day Jear) NAY 2 1 20	2. Registrar's Signature	. parl				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20:48 PM MAY Physician/ Z012 17 MARION BASCOM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE OF MARYLAND MEDICAL CENTER UNIVERSITY . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min 63-22-9769 1 M 2 D F **Director** Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 No MOCO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ ms 23a or must be n Funeral Ŏ items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14 Race - American Indian ıral", or iten Examiner r Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir one. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ristia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည com 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Baltimore 4 Donation 5 Other (Specify) 3 Name and Address of 21. Signature of uneral Service Licen acility meral Home, P.A. 3 N 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYOCARDIAL Physician/ ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Day Month Pregnant at time of death detached 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospita 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 - Pending М Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month. Day, Year) MD MAY 17, 2012 D72527 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. BALTIMORE, MD 21201 TIMOTHY PHELAN, MD. State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 12, 2012 1:50 A M WILLIAM C. BOWDEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 84 OLD MILL BOTTOM ROAD ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours **Director** 241-20-2891 1 ▼ M 2 □ F 90 Usual Residence of Decedent APRIL 9 1922 NORTH CAROLINA 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Xyes 2 No PRINCE GEORGE'S MD UPPER MARLBORO 23a or 10e. Street and Number Switch 10g. Citizen of What Country? Funeral with 2005 WILLOW SMITH LANE 20774 USA items Page 1 and 2 should be filed within 72 hours after death ment of health and Mental Hygiene.
ant If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner muy or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces 1944 Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: BLACK 3 Widowed 4 Divorced 1945 Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ AUTO MECHANIC PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ ARTHUR BOWDEN MARTHA GRATHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 2005 WILLOW THE LANE UPPER MARLBORO, MARYLAND ZANETTA BOWDEN/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) WAYNE MEMORIAL 5/19/2012 DUDLEY, NORTH CAROLINA Signature of Furreral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease shock, or neart failure. Un Immediate Cause (Final or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate st only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital ASSISTEDING 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Profilit, non To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Alawan p 0067230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA DHAWAN MD 9055 Chavulat Drave, Suite 103 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		artment of H		nd Menta	al Hygie	ne 2	012	15999	
		_	Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of L	reatti	2 Da	Reg te of Death	. No.	UIZ	3. Time of Death	
	Physicia Medic		MARVIN KENNETH BELLE				MAY		2 ^{Day}	2012	12:00 PM	
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of D	Death			nty of Death		
لرسب			5004 Holly Spring St.		Suitla	nd			Prin	ice Geo	orges	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b. 274-36-5735 7. 2 F 7.		If Under 1 Year Months Days	If Under 24 Hours		te of Birth onth, Day, Ye	ar)	9. Birthp Coun	place (State or Foreign	
	Director		274-36-5735 X 72	Yrs.			Sep	onth, Day, Ye	1939	ــــــــــــــــــــــــــــــــــــــ	OH	
	and show	ror	10a. State 10b. County 10c. City, To	own or Loc	cation					1	0d. Inside City Limits	
	Maryl 28a-f otified	Director	MD Prince Georges Sui	t1ano	1						1 ☐ Yes 2X No	
	h the la or la be n	al D	10e. Street and Number		10f. Zip Code			10g		of What Coun	itry?	
	th wit	Funeral	5004 Holly Spring St.	Linu	2074				USA			
· ^	or itel	by Ft	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Arreed Forces? 1 YETNA	13. V	Vas Decedent of His f Yes, specify Cubar		? (Specify Yes uerto Rican, o	s or No- etc.)	14. Race - American Indian, Black, White, etc.			
Ö	rs afte ral", Exar	ed b	3 ☐ Widowed 4 ☒ Divorced If Yes, Give Year or Dates—ERA	M - 1	☐ Yes 2 🎦 No	Specify:			Spec	ify: Blac	ck.	
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d 2	ed wi Hygie other ent, tl	Be (12th 17. Father's Name (First, Middle, Last)	meat	Cutter	18 Mother's	Name (First,					
Baltimore, Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. I hand Mental Hygiene. I is marked other than "ratural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	70	Barry Belle				rta Wr		Jon Odnie	inej		
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print)	9b. Mailin	g Address (Street a	and Number o	Number, Ci	r, City or Town, State, Zip Code)				
Σ	nd 2 s ealth a m 27 i			5004	Holly Sp	ring S	t. Su	itlan	d, MI	20746	5	
ore	pe 1 au t of H If itel or oth		1 Burial 2 X Cremation 3 Removal from State	etery, crem	sition (Name of natory or other place		Date		c. Locatio	n - City or To	wn, State	
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Ba	permit. Page 1 and 2 should be to Department of Heatth and Menta Important: If item 27 is marked any injury or other traumatic en once.		21. Signature of Forgral Service Licensee		arshalfdm 308 Suitl					iarylar 2074 <i>(</i>		
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not ente	r the mode of dying	g, such as car	diac or respir	atory arrest,			Approximate Interval Between	
	thysician/		Immediate Cause (Final disease or condition CONGESTIVE HE	EART	FAILURE						Onset and Death	
	Medical Examiner		resulting in death) Due to (or as a consequence		MOVED TT							
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	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	,								
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	death o	iciar	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fetal de 1 Yes 2 No 4 Pregnant at time of death		Ectopic pregnancy Other (specify)	У				Date of delive Month	Day Year	
B	the de by the ached	hysi	9 Unknown									
	s that the gned by the se detach	by P	Part II. Other significant conditions contributing to death but not resultin	g in the u	nderlying cause give	en in Part I.	23	Be. Did tobac	co use co	ntribute to th	e cause of death?	
ds,	requires been sig should b		SLEEP APNEA					1 🗆 Yes	2 🗆 No	3 Prob	pably 4 🗶 Unknown	
ပ	law re has be e 2 sh	Completed	MORBID OBESITY				24	la. Was an autopsy		prior to cor	osy findings available inpletion of cause of	
¥	The ate pag						1	performe Yes 2		death?	2 🗆 No	
Ita	sician certif irecto) Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		_ Othe	r:						
ot v	g Physer this eral d	e: To	27. Manner of Death 28a. Date of injury 28b	. Time of	t 3 □ DOA 28c. Injury	4 ∐ Nursir	ng Home 5	Residence Residence Residence)	
סח	arth. r: Afte	icat	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident ☐ Investigation	injury	M 1 🗆 Y	? Yes 2□No	,					
Division of	or Atter fter de lirecto n by tl	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	farm, stre	et, factory, office			cation (Stree y or Town, S		nber or Rural	Route Number,	
5	pital ours a eral D eral D filled i		29a. Certifier 1 Certifying Physician: To the best of my knowledge	o docth -	equired at the tier-	data and miles	4			oner oc state	4	
	To the Hospital or Attending Physician: within 24 hours after death of the Funeral Director. After this certific completed filled in by the funeral director.	Medical	(Check 2 Medical Examiner: On the bast of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	d/or invest	igation, in my opinio	n, death occur	rred at the tim	e, date and p	lace, and	due to the cau	ise(s) and manner stated.	
_	Voith Com		29b. Signayore and title of certifler		29c. License	number		29d	. Date sigi	ned (Month, L	Day, Year)	
					#D581	171		MA	Y 17	, 2012		
1	va		30. Name and address of person who completed cause of death (Item 23a NAVJIT K. GORAYA, M.D., VAMC, 50	i) (Type, P	rint) TING STREI	ET NW,	WASHI	NGTON,	DC 2	0422/6	88	
Ė	Stat Registra	e ir	30. Name and address of person who completed cause of death (Item 23a NAVJIT K. GORAYA, M.D., VAMC, 50 31. Date filed (Month, Day, Year) 32. Register's Signal (May 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Red		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month **BEVERLY** BUTLER 2012 2037 p May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Hours Country) Director 220-42-1497 1 M 2 XF Apr 14, 1944 68 Usual Residence of Decedent 28a-f show 10a. State the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Forestville Prince Georges 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral **23**a USA 2105 Weber Dr. 20747 items? and 2 should be filed within 72 hours after death Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force "natural", or þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify. Completed **Black** is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Program Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John E. Savoy Hazel E. Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Phillip Butler-Husband 2105 Weber Dr. Forestville, MD 20747 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-22-2012 Clinton, MD Resurrection Cemetery 21. Signature of Funeral Service Licensee Marshalff Marchity Funeral Home of Maryland aclarene Suitland Rd. Suitland, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to or as been signed by the attending physician 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 mor Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page Yes 2 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 🗌 Inpatient 2 🔀 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Natural 28d. Describe how injury occurred 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

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completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature